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**The Incorporation of Visualizations into The Western Model of
Health and Disease: A Manifestation of Cultural Change**

by Judith Barber

**A thesis submitted to the Faculty of Graduate Studies and Research
in partial fulfillment of the requirements for the degree of Master
of Arts**

**Department of Sociology and Anthropology
Carleton University
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The Incorporation of Visualizations into The Western Model of
Health and Disease: A Manifestation of Cultural Change

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Abstract

Over the past twenty years the western model of health and disease has incorporated the practice of visualizations into its treatment of physical diseases such as cancer and arthritis. Hypothesizing that the inclusion of this practice marked a fundamental change in its conceptual framework to understand health and disease, I traced changes within western medicine, as well as those external to it which I suggest challenged its conceptual framework. Using a research methodology which included a literature search as well as fieldwork, I examined, extensively the western conceptualization of visualization therapy, particularly as it related to cancer and arthritis. My research findings showed that the incorporation of visualizations into medical practices is an expression of cultural change, and that many of these changes have taken place within a context of contestation and competition.

Acknowledgment

In doing my thesis I have been reminded, constantly of the beautiful image of the jewel net of Indra in which reality is seen as a multi-dimensional net with each knot a jewel reflecting every other jewel, symbolizing the interconnectedness and interdependence of us all. Although it is I who submitted this thesis, in my view it is the work of many. It grew out of the inspiration, support, guidance and love of so many individuals. These include my thesis supervisor Professor Charles Laughlin, my thesis advisor Professor Derek Smith, my constant friend Lois Chetelat and her husband Gerard, my external examiner Dr. Reardon, all my professors, my thesis informants, friends, colleagues, and Carleton's administration staff such as Nazira Conroy and Kim Mitchell. It is the work too, of my husband who provided me with emotional and financial support (and well-timed prodding!) and of my children who kept me in an uneasy truce with the computer, and who endured early drafts of my thesis, as well as my mental absences! I thank each and everyone of you. Finally, in memory of my mother who loved me unconditionally and made me feel that I could do anything, I dedicate this thesis to her.

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Chapter 1 Introduction

"May my virtuous karma ripen on all living beings, and thus, may they attain both temporary and ultimate happiness." With this strong prayer we imagine that our body transforms into a wishfulfilling jewel, sparkling with light, whose rays reach all six realms of samsara. These rays purify all environments throughout the six realms and bestow upon all the beings inhabiting them everything they could possibly desire. The beings in the hot hells receive cooling rain, those in the cold hells receive warming sunshine, hungry ghosts receive food and drink, animals receive wisdom, humans fulfill all their wishes and needs, demi-gods receive peace and satisfaction, and gods gain freedom (Gyatso, 1988:39).

Like the Tibetan Buddhist who sits in meditation and visualizes his or her body as a brilliant jewel whose rays bring health and happiness to all living beings, visual imagery is deliberately cultivated in some cultures in order to promote human health. Indeed, as I shall discuss further in this chapter, visualizations play a prominent role in Tibetan Buddhism's spiritual and cultural practices such as those pertaining to health. Yet the prevalent Western model of health and disease emphatically has opposed, the use of visual imagery from its scope and practice. Sitting on a firm foundation of mind-body dualism, the prevalent model has rejected any hint of the mind's ability to influence the body's return to health. Yet, within the past twenty years, it is my impression that the use of visualizations has quietly emerged in our western medical practices, particularly in the treatment of diseases such as cancer and arthritis.

This impression grew out of my experience as a physiotherapist practicing in a community-based setting, as well as in conversations with health personnel who work with cancer patients in hospital settings. During my twenty years of practice as a therapist, working with patients who had arthritis, I noted that the focus of treatment was only on the use of physical modalities, as well as exercise, in order to maintain or improve muscle strength and joint mobility. The goal of treatment was to help the patient achieve his or her maximal level of function so that he or she might lead a satisfying life. Now, however, it is my impression that the use of visual imagery has entered the practice of physiotherapy, in conjunction with these physically based measures. In addition, within the field of cancer, I learned

that visualization techniques are part of the treatment program for cancer patients at one of the local hospitals.

The question I asked myself was "why?" Why is visual imagery now being used in the treatment of disease? What has taken place in the West's prevalent conceptualization of health and disease, which has allowed this practice to emerge? What are some of the factors which have contributed to its emergence? How widespread is the use of visual imagery as a form of treatment? Is it advocated by health professionals trained in the biomedical model or is it prescribed only by those health practitioners who practice outside this western model? To what extent do members of the general public believe visualization therapy to be effective in regaining a healthful state? To what extent are these techniques used prior to seeking medical attention? These are some of the kinds of questions that came to my mind as I contemplated this impression of change in Western health practices.

I considered the implications of this apparent shift in Western medical beliefs and practices, in relation to the prevalent medical model in which the Western world has been grounded for the past three hundred years. If, in fact, visualization techniques are found to be incorporated into Western medical practice, then I suggest that it is problematic for the medical model because one of its basic premises is its separation of mind and body. According to this view, what happens in the mind has no effect on the body (or at least in the sense of the mind as healing the body; biomedicine seems to acknowledge the mind's role in *contributing* to disease, but not generally to healing.) Yet it appears that the treatment of cancer and arthritis, although grounded in this mind-body dualism, now includes the use of the mind (in the form of visualizations) to effect a change in the body. How can this be so? This observation brings me to the core issues of my thesis.

Thesis statement

It is my thesis that the use of visualization techniques in the treatment of diseases such as cancer and arthritis, is an expression of cultural change. It is indicative of change at both the theoretical and the practical level. At a theoretical level it is a crumbling of the concept of mind-body dualism which has been a fundamental principle of biomedicine since the seventeenth century. At a practical level it is the explicit incorporation of the mind in

biomedicine's healing practices.

It is my intent in this thesis to explore this emergence of visual imagery in the Western model of health and disease, to hypothesize reasons for its emergence in its medical beliefs and practices, and to do this within this context of a concept of cultural change.

How and why cultures change is a concern of anthropology. In its attempt to understand human cultures over space and time, anthropology has necessarily included within its scope the phenomena of cultural change. Anthropologists such as Pierre Bourdieu have developed theoretical perspectives to deal with these phenomena. In my thesis I examine the incorporation of visualization therapy into Western medical practices through the optic of Bourdieu's theoretical framework of cultural change. In this chapter, I present an overview of Bourdieu's theory and explain, briefly, why I have chosen Bourdieu to understand the inclusion of visualization therapy in biomedicine.

In my attempt to understand the use of visualizations in biomedicine, I acknowledge a personal curiosity. Yet aside from this wish to understand such changes, I suggest that my thesis may contribute to the discipline of anthropology. So that anthropology retains its vitality and its relevance, it must continuously evaluate the frameworks upon which it bases its understanding of human culture. Having chosen Pierre Bourdieu's theory of cultural change in order to understand these transformations within biomedicine, I suggest that I have the opportunity to illustrate the adequacy and continuing relevancy of this theory. Perhaps, then, I may contribute to anthropology's evaluation of one of the theoretical frameworks from which it attempts to understand humankind, and thus, to the development and growth of the discipline itself.

In addition, one of anthropology's hallmarks is to examine cultural phenomenon from a cross-cultural perspective. Thus, I consider the use of visualizations in Tibetan Buddhism in order to provide this type of perspective on the use of visual imagery as a way of regaining or maintaining a state of health. I suggest that it is instructive to examine a system (such as Tibetan Buddhism) in which visualizations play such a prominent role in spiritual and cultural practices.

In this introduction, I discuss the reasons for my interest in

visualization therapy, while identifying the broader implications of its incorporation into Western medical beliefs and practices. I present my thesis statement, namely that the use of visualization techniques in the treatment of physical disease is an expression of cultural change. As well, I outline why I think that from an anthropological perspective it is an important issue to explore. In the remaining part of this chapter, I present an overview of Bourdieu's theory of cultural change, suggesting why I think that his theory might provide an explanation of the changes which are taking place in western medicine. Following this discussion, I present the methodology of my thesis, including the epistemological grounds upon which I base it. Then, I discuss Tibetan Buddhism's conceptualizations of visual imagery. In the concluding part of this chapter, I describe the format of my thesis.

Overview of Pierre Bourdieu's Theory of Cultural Change

Bourdieu holds the view that culture is dynamic (Bourdieu and Wacquant, 1992:18). This dynamic quality rests on his premise that groups within society are in constant struggle either to maintain its status quo or to transform it (Bourdieu and Wacquant, 1992:16-18). Within this context of struggle, groups attempt either to maintain or to gain access to a form of *capital* within a particular *field* in social relations.

Bourdieu defines capital as that entity (may be symbolic) "which is efficacious in a given field...which allows its possessors to wield a power, an influence, and thus, to exist in the field under consideration, instead of being considered a negligible quantity" (Bourdieu and Wacquant, 1992:98-99). Control of this capital gives power to the group who possesses it to retain or transform the ideology and various social structures which exist within that particular domain of culture.

In this thesis I chose to understand cultural change through the prism of Bourdieu's theory. In choosing Bourdieu's theoretical framework, I have been guided by my observations and experiences within the Western biomedical system. For example, in my examination of the Western model of health and disease, I have discovered that new medical technologies have emerged, new medical knowledge has developed, and new therapeutic modalities, such as visualizations are being practiced. These observations reflect, I suggest, Bourdieu's understanding of the way in which culture is

dynamic.

As well, I have chosen Bourdieu's theory of cultural change because I suggest that his argument concerning the way in which cultural change takes place in a context of struggle is being played out in Western medical beliefs and practices. For example, in conducting the research for my thesis I have discovered that physicians who adhere to the dominant model of health and disease are actively, through their licensing bodies, attempting to curtail the practices of those physicians who use modalities outside this dominant model in what is being termed, the alternative system of medicine. These physicians and other alternative health practitioners, with the increasing support of the popular culture, are challenging the basic tenets of Western biomedicine and are struggling to have their beliefs and practices incorporated into the mainstream western model of health and disease. Within biomedicine itself, there is a struggle between physicians, researchers and scientists either to modify or to maintain some of its tenets, such as its notion of mind-body dualism or its reductionist approach to treatment. Such scenarios, I suggest, strongly support Bourdieu's notion of cultural transformation as taking place in the context of contestation between groups within the *field* of medical practice.

In Bourdieu's attempt to understand the nature of the social universe and how it changes, he presents three interrelated concepts of *field*, *habitus* and *capital* which, in his view, express its nature and explain the mechanisms of change.

For instance, the mechanism of social change is inherent to his concept of habitus . Although he defines habitus as a disposition to act, to experience, or to hold a particular belief or attitude because of enculturation in a particular social structure, he argues that habitus may be altered by subjective experience. It is not immune to change (Bourdieu and Wacquant, 1992:18,131-133). Indeed, in my exploration of changes within biomedicine, I will show that some of these changes, such as the development of the discipline of psychoneuroimmunology, or, of biofeedback, grew out of individual experiences, often research-generated, which gave individuals new insights into the relationship between mind and body. These changes in habitus, in turn, created new medical disciplines or techniques. Later, in my thesis I shall discuss this concept of habitus as well as Bourdieu's other two concepts of field

and capital, more comprehensively. In order to understand Bourdieu's conceptualization of cultural change (Bourdieu and Wacquant, 1992:16-18, 94-104, 120-137). At that time I shall relate them to the changes within biomedicine.

So that I might illustrate why I chose Bourdieu's theoretical framework, I have presented several examples of congruency between Bourdieu's theory of cultural change and the changes within biomedicine. It is now essential for me to discuss my research methodology.

Research Methodology

The purpose of my methodology is to gain an understanding of how visualizations are understood within the context of physical disease as well as within the context of cultural change. In framing my research methodology, I considered three aspects: the limits which I placed on my research, its focus, and finally, its epistemological considerations.

With regard to the limits which I placed on my research, I chose specific geographic and time frameworks, as well as focusing on a particular type of imagery (visualizations). Upon consideration of a time frame, I chose to limit my research to a span of twenty years, as I suggest that such a span is adequate to discern changes within a social field in contemporary social formations. Concerning a geographic framework, I limited my research to Canadian and American conceptualizations of visualization therapy. In making these decisions, practical considerations prevailed. Most popular literature on visualizations has come from the United States, such as the pioneering work of Carl Simonton and his wife Stephanie who, in the 1970's were using visualizations to treat their cancer patients (Simontons, 1978:3-260). For these reasons, I included an American perspective on visualization therapy. Taking this lead, I focused on both American and Canadian journals and periodicals in my review of professional literature on visualizations. I tried to counteract what might be considered an American bias, by doing fieldwork in the Ottawa/Hull area. In addition, I attempted to survey Canadian magazines and newspapers, in order to ascertain the Canadian perspective on this issue, as well as its attitude towards change within the field of medicine.

Because of the limits of this type of thesis, I was limited to considering

only one type of imagery in healing. I focused on its visual aspect. Imagery "involves all sensory channels-sight, sound, touch, kinetics, taste, smell and what Dr. Eugene Gendlin call "the felt sense"(Brigham,1994:35). Thus, it includes all these sensory pathways, not just the visual type.

Brigham(1994:35,128) states that although our particular culture is especially attached to the visual sense of imagery, visualizing is only one aspect, the one that deals primarily with the sensory modality of sight rather than the totality of sensory information. Reflecting the bias of my culture, I chose to focus on this type of imagery in my thesis. I chose visual imagery because my introduction to imagery and healing was via the work of the Simonton's who used visualizations in the treatment of cancer in the 1970s(Simontons,1978:3-260). At that time, visual imagery was the predominant sensory pathway used to promote healing in cancer patients. As I shall point out further on in my thesis, the use of imagery in healing has evolved to include other sensory pathways such as auditory and kinesthetic modes.

In considering the second aspect of my methodology, its focus, I was concerned with how and where I could obtain my knowledge about visualizations. In this context, I decided to base it on a literature search as well as on fieldwork. In conducting my literature search I began by conducting a Medline search from the years 1975 to 1995 inclusive. A Medline search covers international literature on biomedicine, including the allied health fields, the biological and physical sciences, humanities, and information science as they relate to medicine and health care. Information is indexed from approximately 3,600 journals published world- wide. The purpose of this computer search was to identify, the pattern of use over time of visualization therapy in the treatment of cancer and arthritis, and to determine how visualization therapy was being conceptualized in these journals. Reflecting the prevailing mind-body split in western medicine, I conducted a literature search of the psychological and sociological literature by reviewing the PsycLit and Sociofile on the CD ROM, covering the years 1975 to 1995. PsycLit is a summary of world's serial literature in psychology and related disciplines, and is compiled from a psychology information database. It covers 1300 journals in twenty -seven languages in approximately fifty countries. Sociofile has index to and abstracts of the literature of sociology from more than 2000 journals published world-wide. Its data base covers 1974 up to the

present.

Furthermore, in considering questions such as, how widespread the use of visualization therapy is in the public domain, to what extent do members of the public believe its use to be effective in maintaining or regaining its health, and does it use these techniques prior to seeking mainstream medical attention, I looked at the popular literature on visualizations, as well surveying magazines and newspapers.

As well as searching the literature on the use of visualizations in healing over time, I did field research. Its purpose was to relate what I discovered from my literature search to what I found in the 'real world' or at least the 'Ottawa Hull world'!

In my fieldwork, I interviewed an oncologist, a nurse and a social worker who teach visualizations, two physiotherapists, as well as a patient who has experienced visual imagery for the treatment of cancer. In conducting my fieldwork I adopted a research approach which uses a semi-structured interview format. It was unstructured in the sense that I encouraged my informants to say what they wished to say, in their own words and at their own pace, about their understanding of visualizations. However I structured it in that I had an interview guide, a list of questions which I wanted to cover. Bernard(1988:204-5) tells us an

interview guide is a list of questions and topics that need to be covered in a particular order. The interviewer still maintains discretion to follow leads, but the interview guide is a clear set of instructions....

In my case, I didn't feel that I should ask them in a particular sequence, but I wanted to be sure that I completed the interview having covered what I felt I needed to know. In using this research procedure, I adopted a qualitative approach to my fieldwork. This brings me to a discussion of the third aspect of my methodology. Having discussed the first two aspects of my methodology, its limits and its research focus I considered this third aspect: its epistemological basis. In my decision to use a qualitative approach to my interview, I chose to understand the meaning of a social situation from the perspective of the informant. Burgess(1984:3) states

that fieldwork involves a phenomenological perspective whereby researchers attempt to understand the meaning of events for people in particular situations. The focus is upon the way in which participants interpret their

experience and construct reality.

In another epistemological consideration, I decided to ground my field research in a reflexive epistemology which is based on the fundamental principle that anthropologists are an inseparable part of the social world which they study, and as such they influence the information which they obtain in the research setting. As Geertz(1973:9) states: "What we call our own data are really our own constructions of other people's constructions of what they and their own compatriots are up to...". Such an approach differs from the positivistic perspective which argues that in interactions with others in the social world, one can be a neutral observer of an objective reality, a reality which exists independently of oneself. Not true, argue Hammersley and Atkinson(1991:14); they state that the fact that anthropologists are part of the social world they study "is not a matter of methodological commitment, it is an existential fact."

With this view in mind, it followed that I as a researcher was an inherent component of the research process, affecting all aspects of its process. My gender, age, marital status, as well as my personal idiosyncrasies, strengths and weaknesses affected all my interactions with my informants, including the data which I received. Similarly, my feelings affected these interactions. As Hammersley and Atkinson(1991:165) state:

In the first place our feelings enter into and colour the social relationships we engage in during fieldwork. Secondly, such personal and subjective responses will inevitably influence one's choice of what may be noteworthy... problematic and what appears to be mundane or obvious. One often relies implicitly on such feelings, and their existence and possible influence must be acknowledged and, if possible, explicated in written form.

Another issue which I viewed as crucial in doing my research concerned the notion of conducting fieldwork in one's own culture. Burgess(1984:22) reflects on this issue and asks the question:

Does familiarity with one's culture breed, not contempt but rather a kind of blindness? Will researchers recognize patterns in a society in which they are thoroughly acculturated?...Will researchers give full coverage to situations with which they are already familiar?

This issue, I concur, was a potential dilemma. and one of which I made

every attempt to be mindful. I had postulated that the fact that I was aware of this danger would help to guard me against it. However, I quickly learned in conducting my fieldwork, this awareness didn't help a bit! Also, I proposed that my adoption of a reflexive approach to fieldwork which of itself necessitates a level of self-awareness in social interactions would, I suggest, heighten my self-awareness in the whole research process, including situations with which I was already familiar. Again, as I shall discuss in my chapter on fieldwork, this reflexive approach didn't help to prevent cultural blindness either! Having discussed my methodology, I now explore the use of visual imagery in Tibetan Buddhism in order to provide somewhat of a cross-cultural perspective from a cultural setting in which visualizations are an essential component in spirituality, healing and other cultural domains.

Part of this exploration is from a personal, phenomenological perspective for I describe some of my own visualization experiences, as a Vajrayana Buddhist practitioner.

Visualizations in Tibetan Buddhism

Visualizations are particularly prominent both in Tibetan spiritual practices which promote certain positive states of mind, as well as those spiritual practices which specifically involve healing such as the Medicine Buddha Puja. In my exploration of visualizations, firstly, I consider their role in their practice of Vajrayana Buddhism. Then, I describe a healing ritual which I attended in Ottawa on May 25, 1996 which also involves the use of visualizations.

Vajrayana Buddhism came to Tibet in the seventh century from India(Humphreys,1951:190-191). When the Tibetans were forced into exile in the latter 1950s and early 1960s, they brought their religion with them. Since that time many western people have been exposed to this type of Buddhism.

The word *Vajrayana* is a Sanskrit term which means 'diamond vehicle' and refers to the unshakable, diamond awareness of reality that characterizes the fully awakened state of enlightenment. *Vajra* means 'indestructible' while *yana* means 'vehicle', referring to the methods whereby this ultimate goal of spiritual awakening and fulfillment is reached(Landaw and Weber,1993:4). In Vajrayana Buddhism, one of these methods is visualization of Buddhist deities as a means of spiritual transformation.

From a Buddhist perspective, to be healthy in the ultimate sense one becomes awakened to the true nature of reality, which is the lack of inherent self-existence of phenomena. Health, therefore has a spiritual dimension. Conversely, the fundamental causes of disease are the thrice deluded mind states of ignorance, attachment and hatred. Ignorance is understood to mean the ignorance of the true nature of reality, which embodies the idea that all phenomena lack an inherent existence.

According to Vajrayana Buddhism, these root delusions lead to imbalances of bodily 'humours', various bodily constituents and waste products with the result that physical disease occurs (Landaw and Weber, 1993:100). Although disease may be alleviated by medical treatment, to remain healthy, this physical transformation must be accompanied by a spiritual conversion. As Landaw and Weber (1993:101) state: "If ignorance and its associated delusions remain festering inside, sooner or later they will give rise to disease and the recurring miseries of cyclic existence".

In their attempt to bring about this spiritual transformation, one of the methods Vajrayana Buddhists use is visualization of Buddhist deities. Landaw and Weber (1993:6) state that

visualization is the process of becoming intimately acquainted with positive and beneficial states of consciousness as they are envisioned in our mind's eye in the form of enlightened beings and other images. Each visualized image functions as an archetype, evoking responses at a very subtle level of our being and thereby aiding in the delicate work of inner transformation.

Elaborating, Landaw and Weber state that when we generate an image of a meditational deity such as Avalokiteshvara who symbolizes compassion, and we focus on this image with single-pointed concentration, we stimulate the growth of our own compassion. Furthermore, the more we practice this visualization the more profound the effect. Indeed, Landaw and Weber (1993:7) tell us that

eventually our mind can take on the aspect of its object to such an extent that we transcend our ordinary limited sense of self-identification and actually become Avalokiteshvara: compassion itself, or whatever enlightened quality we have been concentrating upon.

Landaw and Weber emphasize that in order to achieve this enlightened self-transformation, we must internalize the image to the extent that we identify with it at the deepest level of our consciousness. To do this we must

learn to visualize the image in its fullest detail, without forgetting it. Furthermore, we must learn to experience our meditational deity, not as inert and two-dimensional but as a living radiant being. This experience is crucial because as Landaw and Weber(1993:7) tell us, "it is only by seeing the meditational deity as truly alive yet transparent, radiant and empty of concrete self-existence, that our mind- which itself is boundless, clear and luminous -can be transformed in the desired manner". According to Landaw and Weber, the reason the Vajrayana practitioner comes to experience these deities as alive is because these images symbolize forces which possess a vital reality of their own.

They are not mere arbitrary, creations of a limited mind or the fanciful product of an artist's imagination. Each particular image owes its existence to the fully enlightened mind from which it originally sprang and conveys the timeless qualities of such a boundless consciousness(Landaw and Weber,1993:7).

In addition, Landaw and Weber tell us that vajrayana practitioners who decide to choose this type visualization practice do not casually choose a particular image and make it their central object of meditation, rather "the deity to be practiced is presented to the disciple within the context of an initiation, or ceremony of empowerment, presided over by a qualified tantric master who has trained in the methods of the deity in question and can therefore transmit to the disciple all that is necessary for contacting its essence"(Landaw and Weber,1993:7-8).

Two summers ago as a novice Buddhist, I took a tantric empowerment from a Tibetan spiritual master who has been residing in England since 1977. Up to that time my interest in Buddhism had expressed itself in one silent ten day retreat, several years of meditation of focusing on the breath and intellectual knowledge from books and courses on Buddhism given here at Carleton university. During those two weeks of the empowerment and teachings, my mind was assaulted by the gigantic statues of many- armed, variously coloured, wrathful, and/ or peaceful Tibetan Buddhist deities, by endless chanting, and sounds of bells and horns. I experienced the empowerment and the commentary, both in a daze and in awe of the rituals happening around me. I returned home with vows and commitments to a daily practice of meditational deity called Vajryogini, a brilliant red, female Buddhist deity who symbolizes the notion of bliss and emptiness. Since that

time I have, with relatively few, albeit large gaps, kept those commitments. One of them is to do a daily practice, another is to keep my practice secret in terms of its details.

As part of my daily practice, I am to imagine myself as Vajrayogini. In doing so I attempt to follow Landaw and Weber's advice that we should try to experience our meditational deity as alive, so that "our mind-which itself is boundless, clear and luminous - can be transformed in the desired manner."(Landaw and Weber,1993:7)

Vajrayogini is a female Buddha symbolizing the wisdom of the inseparability of great bliss and emptiness. Landaw and Weber describe her.

Vajrayogini is sixteen years old, radiantly beautiful with a youthful freshness and vitality.... She has three eyes, symbolizing her enlightened ability to see past, present, and future simultaneously....In her right hand is a curved flaying knife marked by a vajra, and in her left she holds a skull-cup filled with blood, as if she were about to drink from it....These implements symbolize respectively the wisdom that cuts through the fabrications of ignorance and the blissful clear light consciousness that has unified with this penetrating wisdom.... Her body is naked, demonstrating Vajrayogini's freedom from ordinary conceptions and appearances....Her body itself represents the sixth perfection, wisdom. Around her neck hangs a garland of fifty human skulls symbolizing the purity of her speech(Landaw and Weber: 141-142).

In my attempt to be her, I visualize her in as much detail as I can, and as vividly as I am able. However, I find that I experience her image as shadowy, fragmented, and far from distinct or vivid. I am never able to see a complete image. Rather, I see her left hand with a partial skull-cup..., a knife... her face. Even these images are vague and incomplete. Although, I know that her every detail is symbolic, I do not think of this as I try to visualize her. My job is to visualize her, not to do a symbolic analysis of her. I'm in this for spiritual growth, not to satisfy my intellectual curiosity!

What happens in the process of my visualization, is that I vacillate between seeing her 'out there', however fragmented, and having the sense or 'feeling' that I am her. Then, it becomes more of a kinesthetic imagery. I 'feel' her arm upstretched, holding a skull cup; I 'feel' her right hand holding a knife, her black hair hanging down her back.

Recalling Landaw and Weber's statement that every visualized image functions as an archetype, evoking responses as a very subtle level of our being and leads to a transformation of our mind and remembering that when

we focus on a particular image in single pointed concentration, particularly if the image is vividly experienced, we stimulate the development of whatever quality of image embodies, I wonder about the extent of my understanding of the Buddhist concept of wisdom. Have I any experience of the notion of 'emptiness', this idea of the lack of inherent existence of phenomenon which this concept entails, as a result of doing this visualization? I don't know. Perhaps, things don't seem so solidly 'out there'. Perhaps, I have a sense of the world as an imputation of my mind. What I do know, is that these experiences are part of a spiritual path which innumerable other beings who have eventually become enlightened, have taken, and one which I have chosen to take. Visualizations are part of a method for this spiritual transformation for the reasons Landaw and Weber have given. So I will keep doing them. Its a path, I remind myself, a process. So, inspired, I continue....

As I have just noted Vajrayana Buddhism defines health as having a spiritual dimension as well as physical and mental aspects. Visualizations as a spiritual practice help to bring about this holistic state of health. At the same time, visualizations also play a role in dealing with the physical dimension of illness. In their healing ritual called the Medicine Buddha, the physical aspect of disease is acknowledged and considered. I was present at this ceremony when it was performed here in Ottawa by visiting Tibetan monks on May 25, 1996.

Along with approximately forty other individuals, I was both observer and participant in the Healing Ceremony of the Medicine Buddha which took place at the University of Ottawa. It was performed by twelve Tibetan Buddhist Monks from the Seraje Monastery in southern India who have come to Canada to raise money for their monastery which needs more space to accommodate refugees from Tibet.

As we stood quietly, waiting for their appearance, twelve Tibetan Monks in saffron robes filed quietly on stage and sat down, cross-legged, each on purple meditation cushion which had been placed in two rows of six, in a v shaped arrangement, with the wide end of the 'v' nearest the audience. The narrow end of the 'v' ended at a table, upon which had been placed seven incense bowls, with two crossed incense sticks in each bowl. The incense was unlit. A beautiful vase of flowers sat at the back, left corner of this table. Above the table, on a wall was a picture of the Medicine Buddha. Landaw and

Weber have described him: The Medicine Buddha is depicted wearing the robes of a monk and is seated cross legged, with his left hand resting in his lap holding a begging bowl filled with medicinal nectar and fruit. "His right hand rests upon his knee with palm facing outward in the mudra of granting blessings and holds a stem of a myrobalan plant, renowned as the king among medicines because of its effectiveness in treating both mental and physical disease"(Landaw and Weber,1993:99). The Medicine Buddha's most prominent feature is his colour, the deep blue of the gemstone lapis lazuli which is said to have a strengthening and curative effect on those who wear it. Moreover, the colour blue has been demonstrated to have a healing effect on those who use it in their visualizations(Landaw and Weber,1993:99-100).

Within moments, the monks began to chant prayers in Tibetan, filling the air with deep strong notes which reached out into the room to touch us all. Some of the voices sang two or three notes simultaneously, in what to western ears can sound odd. Having heard this type of singing and these chants now for the past several years, I found their voices both familiar and surprisingly moving. The head monk who sat at the head of the narrow end of the 'v', on its left side, had in front of him, a small table with a cloth upon which was placed a plastic glass filled with rice. As well as a bell and a 'vajra', a small, scepter-like object sat on this table. Periodically, still chanting, this monk would reach into the glass of rice, remove several grains and throw them over his right shoulder. At times, he would simultaneously ring the bell and make hand gestures while holding the 'vajra'.

We are told that

during the ceremony seven Buddhas are visualized in the one form of Medicine Buddha within the Pure Land or mandala called Lapis Jewel Land....From his Pure Land...the Medicine Buddha shines forth brilliant rays of azure blue light. This light is the wisdom and compassion of Medicine Buddha in the form of healing medicine for the benefit of all living beings(Medicine Buddha Brochure)

During the ceremony, we were given an oral transmission of the Medicine Buddha mantra by the head monk. As part of this transmission, we were asked to repeat a mantra three times. According David Gould(personal communication, May 25,1996), one of the organizers of this event and himself a Buddhist, as a result of this transmission we could now incorporate the Medicine Buddha practice, as a sutra practice, into our other spiritual practices. When the ceremony finished, the monks stood up, as did we. Quietly,

they left the stage.

According to Geshe Kelsang Gyatso Rinpoche(1995:3), the Medicine Guru is a an emanation of Buddha's Truth Body, and his function is to release living beings from outer and inner sickness by bestowing blessings upon them. Kelsang Gyatso(1995:3) states that "by relying upon Medicine Guru sincerely, living beings in these impure times can be cured of heavy physical and mental disease, and find release from the internal pain of the three poisons: attachment, anger, and ignorance".

This healing ritual involves the practice of visualizations. Those who do this practice are asked to meditate on the Medicine Buddha and to recite his mantra. They are requested to

feel that brilliant blue light shines from his body and enters your body, giving you energy and inspiration. Think that this light then removes all negativities, and obstructions from your body and mind. Next, see that Medicine Buddha shines this brilliant blue light outwards towards all living beings. All living beings experience joy, find inner peace and become free from all suffering. Hold to these visualizations without distraction and strongly try to feel that this is actually happening (Medicine Buddha Ceremony brochure).

Having discussed Tibetan Buddhism's conceptualization and some of its practices regarding visualizations, I now in the conclusion of this chapter present the format of my thesis.

In this introductory chapter, I have introduced the topic of my thesis, briefly discussed its importance to anthropology, presented an overview of Pierre Bourdieu's theory of cultural change through which I will analyse my thesis, described my research methodology and discussed the use of visualizations from the perspective of Tibetan Buddhism. In Chapter Two, entitled *Tracing the Changes*, I focus on three areas. In the first section I outline the basic tenets of the prevailing western model of health and disease. As it is my intent to show that visual imagery is an expression of change in western medical beliefs and practices, it is incumbent upon me to reveal the tenets of the prevailing model clearly as possible so that one has a keen understanding of where the movements of change are taking place. In the second section of this chapter, I explore some of the developments in the western field of health which I suggest are indicative of change in the prevailing model. Thus, I discuss a relatively new discipline within

biomedicine, the field of psychoneuroimmunology which is currently challenging some of the basic tenets of the prevailing model of biomedicine, especially its doctrine of mind-body dualism, as well as its reductionist approach to treatment. Here too, I discuss the alternative systems of medicine which are increasingly encroaching upon dominant approaches in western culture for the patronage of the public in matters of health and disease and, as well, are attempting to remodel the western ideology and practices of health and disease. In the third and final section of this chapter, I explore extensively the use of visualizations in western settings, including their conceptualization beyond the domain of the health field. Also in this section, I discuss how visualization therapists conceptualize and use visual imagery as a therapeutic modality in the treatment of cancer and arthritis.

In the third chapter entitled *Pierre Bourdieu: A Theory of Cultural Change*, I explore Bourdieu's understanding of cultural change. Using his concepts of field, habitus and capital, I examine the changes and challenges to biomedicine with the purpose of determining how well Bourdieu's theory explains these changes. Specifically, I examine the phenomenon of alternative systems of medicine and their relationship to biomedicine in terms of Bourdieu's concepts.

In chapter four, entitled *Fieldwork: What Quackery is This!*, I present findings from my fieldwork on visualization therapy in the treatment of cancer and arthritis, examining them within the context of social change. In this chapter, I weave my epistemological considerations into my fieldwork interviews, using an italicized font.

In chapter five, entitled *Fieldwork analysis: Blaming the Victim*, there are two parts. In the first part of this chapter, I relate the conceptualizations of visual imagery which I found in my fieldwork to those which I discovered in doing my literature search. As well, I analyse my fieldwork data, discussing several issues which are crucial to the acceptance or rejection of visualizations as a part of biomedical practices. In the second part of chapter five, I examine my fieldwork on visualizations from Bourdieu's conceptual framework of cultural change.

Finally, in my concluding chapter, I return to my thesis statement and after summarizing the issues which I explored in my thesis in order to determine its validity, I present my principal findings.

Chapter 2

The Western Model of Health and Disease: Tracing the Changes

In this chapter, I analyse the changes which I suggest have led to a shift in the dominant western framework of health and disease. In order to do this, I have divided this chapter into three sections. In the first section, I discuss western culture's biomedical model of health and disease. In the second part, I discuss the changes within western culture which are challenging this framework. In the conclusion of this chapter, I explore the use of visual imagery in Western culture.

In this part of my thesis, I discuss the biomedical model of health and disease which has existed as the prevailing framework through which western culture has conceptualized its understanding of health and ill-health for the past three hundred years. Through this discussion, I provide a reference point from which these changes which I propose are contributing to the upheaval and modification of this three hundred year old framework, are occurring. In this context then, I discuss the premises upon which this model is based: its biological basis for understanding illness, its mechanistic understanding of the body; its notion of mind-body dualism, its conceptualization of the causality of disease and lastly, its epistemology, that is, its methodology to understand illness.

In addition, in my discussion of the concept of mind-body dualism, I outline western culture's current understanding of this concept, revealing that although modern western medicine has retained the concept, its meaning has altered. This modification in meaning has implications for western understanding of the nature of mind and its relationship to brain.

Furthermore, in my discussion of this premise of mind-body dualism, I outline modern medicine's concept of the placebo effect, as well as its notion of psychosomatic illnesses and show how these concepts relate to its dualistic stance toward mind and body.

1. The Biomedical: The Foundation

Every culture seeks to explain illness and to derive strategies which will return its sick members to a state of health, however that state is defined.

Western culture is no exception. Its principal model of health and disease is a biomedical one. According to this model,

the human body is regarded as a machine that can be analysed in terms of its parts; disease is seen as the malfunctioning of biological mechanisms which are studied from the point of view of cellular and molecular biology; the doctor's role is to intervene, either physically or chemically, to correct the malfunctioning of a specific mechanism(Capra,1982:123).

Moreover, because disease is generally assumed by biomedical practitioners to be explained on the basis of malfunctioning of measurable biological (somatic) variables, it leaves little room within its framework for the social, psychological, and behavioural dimensions of illness(Engels,1977:130). This understanding of disease resonates in the plea from a contemporary physician to his colleagues

to concentrate on the 'real' diseases and not get lost in the psychosociological underbrush...The physician should not be saddled with problems that have arisen from the abdication of the theologian and the philosopher(Engels,1977:129).

Furthermore, such an understanding of disease implies that physical ailments are produced by physical causes and should be treated almost exclusively with physical interventions(Simontons,1978:48).

Yet, Western culture has not always conceptualized its understanding of illness in this manner. From the fifteenth until seventeenth century, healers in Western culture made physical interventions, but also treated those who fell ill within a social and spiritual context as well. Illness was viewed as "a disorder of the whole person, involving not only the patient's body but his mind; his self-image, his dependence on the physical and social environment, as well as his relation to the cosmos and the deities"(Capra, 1982:124). In addition, in their rituals, healers deliberately invoked the power of the mind to help the patient in order to evoke the natural healing powers that all living organisms possess(Capra, 1982:124-125).

In considering the forces which brought about this fundamental shift in the beliefs and practices of western medicine and led to the development of the biomedical model, one man and his ideas stand out: French philosopher Rene Descartes. Descartes' epistemology of reductionism, his view of the body as a machine, as well as his doctrine of mind-body dualism, became the major tenets of this new framework of health and disease.

Déscartes' conceptualization of reductionism is based on the understanding that complex phenomena can be understood by reducing them to their elemental parts and looking for the mechanisms through which these parts interact (Capra, 1982:47). This epistemology was fueled, over the following centuries, by developments in biology. As Capra (1982:127) states:

the rise of modern scientific medicine began in the nineteenth century with the great advances made in biology. At the beginning of the century the structure of the human body, even down to minute details was almost fully known. In addition, rapid progress was being made in the understanding of physiological processes. Thus, biologists and physicians, faithful to the reductionist approach turned their attention to smaller entities.

As a result of their attention on smaller and smaller elements within the body, which today include cellular and molecular levels of the body, physicians came to pay little attention to the psychosocial and spiritual dimensions of disease. Consequently, they began to lose sight of the patient as a total human being, forgetting that illness has a wider social, environmental, psychological and spiritual context. Health itself became defined as the absence of disease rather than a concept which included these broader dimensions. According to Capra, the reductionistic approach to understanding illness sounded the death-knell for the inclusion of the notion of healing within biomedicine because, as he argued, healing cannot be understood in reductionist terms. In his view, the concept of healing moves beyond the purely physical phenomenon of biomedicine, to involve the interplay among the physical, psychological, social and environmental aspects of human condition (Capra, 1982:124).

A second theoretical concept of Déscartes which became a premise of biomedicine concerned the notion of the human body as a machine. Here, Déscartes was adopting the prevailing metaphor of his time: the world as a machine. In conceptualization of the human body as a machine, Déscartes drew an analogy between the clock and the human being:

I consider the human body as a machine... My thought compares a sick man and an ill-made clock with my idea of a healthy man and a well-made clock (Capra, 1982:62).

Capra relates the consequence of Déscartes' metaphor of body as machine on the conceptual framework of Western medicine, stating: "three centuries after Déscartes, the science of medicine is still based_ ... _ on the

notion of the body as a machine, of disease as the consequence of breakdown of the machine, and of the doctor's task as repair of the machine"(Capra,1982:123).

In forming his concept of mind-body dualism which became a cornerstone of the Western model of health and disease, Descartes was guided by his rejection of traditional knowledge as imparted by the church and philosophy, as well as folk culture, and by his adamant belief in the paramouncy of scientific knowledge as the truth. He argued that:

all science is certain evident knowledge. We reject all knowledge which is merely probable and judge that only those things should be believed which are perfectly known and about which there can be no doubts(Capra,1982:57).

It was as a thinker that Descartes defined himself as a human being. Although he acknowledged his existence, he wanted to know its essence. He stated: "I know that I exist, and I inquire what I am, I whom I know to exist"(Bradley,1964:25). Contemplating further, he concluded:

To speak accurately, I am not more than a thing which thinks, that is to say a mind or a soul, or an understanding, or a reason, which are terms whose significance was formerly unknown to me. I am however, a real thing and really existing but what thing? I have discovered: a thing which thinks.....What is a thing which thinks? It is a thing which doubts, understands, conceives, affirms, denies, wills, refuses, which also imagines, and feels(Bradley,1964:24-25).

In his contemplation of his mind and body, Descartes considered them to be of two separate substances. They consisted of a thinking substance and a corporeal substance, both created by God and both fundamentally different and distinct(Bradley,1964:44). Elaborating, he stated:

Now, on the one hand I see that nothing belongs to my essence, as affirmed in the Cogito, ergo sum, except that I am a thinking and unextended thing, while on the other hand I have a clear and distinct idea of body as an extended and unthinking thing. And it follows that 'this I (that is to say, my soul by which I am what I am) is entirely and absolutely distinct from my body, and can exist without it(Copleston,1960:116).

It was this conceptualization of the mind and body as distinct and separate that was incorporated into the mind-body dualism of the biomedical model. Capra discusses some of its consequences. He states that "Descartes' strict division between mind and body led physicians to concentrate on the body machine

and to neglect the psychological, social, and environmental aspects of illness"(Capra,1982:126). Furthermore, Capra argues that Descartes' dualism has affected the practice of health care by fracturing the medical profession into two separate camps, with minimal communication between them: it is the physician who deals with physical disease, while the psychiatrist and psychologist concern themselves with treating the mind. The outcome, Capra argues, is that there is a

gap between the two groups (which) has been a severe handicap in the understanding of most major diseases, because it has prevented medical researchers from studying the roles of stress and of emotional states in the development of illness...the link between emotional states and illness, although known throughout the ages, still receives little attention from the medical profession(Capra,1982:142).

In addition to Descartes' contribution to the kind of conceptual framework underlying biomedicine, several other developments in the western world have helped to build this model of disease. Throughout history, western physicians have debated whether or not a disease occurs as the result of a single factor or is the outcome of a constellation of factors acting concurrently. In the nineteenth century this debate was settled in favour of the single- cause theory. It was then that medicine embraced the idea of the germ theory of disease which argued that specific diseases were caused by specific microbes, thus, establishing the notion that a particular disease is caused by a single factor rather than by a constellation of factors acting simultaneously(Capra,1982:128). Moreover, as Capra(1982:128) noted: "The idea of a disease being caused by a single factor was in perfect agreement with the Cartesian view of living organisms as machines whose breakdown can be traced back to the malfunctioning of a single mechanism".

In summary, for the past three hundred years, the western model of health and disease has defined illness or disease in physical terms, within a metaphor of the body as a machine which, when it breaks down, results in illness. It has incorporated Descartes notion of mind-body dualism which has led physicians to focus on the body in diagnosis and treatment of illness. This model considers the mind to be the primary domain of the psychologists and psychiatrists, with little interaction between these health professionals and physicians. Biomedicine's epistemological approach is one of reductionism which seeks out answers to the causes of disease in smaller and smaller parts

of the body which now include cellular and molecular levels. Furthermore, the cause of disease is seen to derive from a single source. Social, environmental, psychological and spiritual contexts are considered largely extraneous as causes of disease; they are not viewed as crucial in bringing an individual back to a healthful state.

In the next section I shall return to the concept of mind-body dualism and examine, more intensively, biomedicine's current understanding of this concept.

Current Understanding of Mind-body Dualism within Biomedicine

Firstly, although modern biomedicine has retained the concept of mind-body dualism, its meaning has changed since Descartes' time. Secondly, although in its current understanding of mind-body dualism, biomedicine explicitly denies the effect of the mind in healing or in the onset of illness, I suggest that it implicitly acknowledges the mind's impact on the body in its recognition of the placebo effect and psychosomatic illness.

An examination of Descartes' dualism of mind and body, has shown that Descartes viewed mind as distinct from brain, although it was linked to it. According to Descartes, the mind or soul resided in the brain, specifically in a gland within the brain; it was a site of communication between body and mind. Yet, the mind was not the brain itself.

Descartes stated:

that I am not only lodged in my body as a pilot in a vessel, but that I am very closely united to it, and so to speak intermingled with it that I seem to compose with it one whole. For if this were not the case, when my body is hurt, I, who am merely a thinking thing, should not feel pain, for I should perceive this wound by the understanding only, just as the sailor receives by sight when something is damaged in his vessel....it resided in the brain which was the site of communication between mind and body(Bradley,1964:30).

Further, he proposed that:

The soul has its principal seat in the little gland which exists in the middle of the brain, from whence it radiates forth through all the remainder of the body by means of the animal spirits, nerves, and even blood, which, participating in the impressions of the spirits, can carry them by the arteries into all the members(Bradley,1964:47).

In examining the biomedical model's understanding of the nature of the

mind and body and their relationship, one learns that with the advent of modern science the mind has come to be regarded as the special and sole property of the brain (Dossey, 1992:109). It takes a philosophical stance known as central state materialism which denies that the mind is a spiritual entity but is a physical one. This stance holds that the mind is the brain, specifically, it is the central nervous system of the brain (Campbell, 1970:88). Furthermore, it states that the nature of their relationship is that the mind is a cause of behaviour through the neurological changes which take place in this central nervous system of the brain:

...bodily activity is caused by neurological changes in the central nervous system. The mind the cause of behaviour turns out to be the brain (Campbell, 1970:87).

In continuing to explore biomedicine's conceptualization of mind-body dualism, I would argue that although biomedicine explicitly rejects the role of the mind in returning an ill person to a state of health, it does acknowledge the impact of the mind *implicitly*, in the healing process with its notion of the placebo effect.

The term *placebo effect*, is a word derived from the Latin word *placebo*, meaning 'I will please'. In terms of medical usage, it was defined in 1803, as "an epithet given to any medicine adapted more to please than benefit the patient" (Schonauer, 1994:78). Turner et al (1994:1612) propose that the placebo effect is "a change in a patient's illness attributable to the symbolic import of a treatment rather than a specific pharmacological or physiological property". As an example, Turner describes a study in which sixty-four percent of patients who underwent a sham tooth grinding procedure for a painful jaw (temporomandibular disorder) reported total or near-total reduction of their symptoms (Turner et al, 1994:1610).

Biomedicine argues that the placebo effect must be "controlled" for in any therapeutic drug trial so that the efficacy of a drug is found to be due to its pharmacological properties rather than the patient's imagination (Achterberg, 1985:86). However, as Achterberg (1985:86) states, its tenacious presence in clinical studies of drugs or in surgical procedures is

stark and incontrovertible testimony to the role of the imagination in health. The wonder is that scientists have invested so much effort in "controlling" for it, and so little in identifying how it might be used to best advantage in health care.

Moreover, according to Norman Cousins,

what is most significant about placebos is not so much the verdict they supply or the efficacy of new drugs as the clear proof that what passes through the mind can produce alterations in the body's chemistry. These facts also indicate that the same pathways and connections that come into play through the use of placebos can be activated *without* placebos. The main ingredient is the human belief system (Achterberg, 1985:86).

In its categorization of illness as *psychosomatic*, I would argue that biomedicine gives implicit recognition of the impact of the mind in the onset of disease. Since the mid- twentieth century biomedicine has acknowledged the fact that physical illness could have some psychological impact on an individual, yet as Brigham (1994:19) points out, "to speak of the activities of one's mind having an impact on one's body remained almost heretical in most respected circles". Even the work done by Hans Selye, Flander Dunbar and associates in psychosomatic illness in the area of stress in the 1950's did not dispel this separation of mind and body. Their work revealed that psychosocial factors are implicated in the onset of certain physical conditions. For example stress plays a role in producing medical problems such as asthma, ulcers and migraines (Brigham, 1994:19). Yet, Brigham (1994:19) asserted "most scholarly review of this work at that time found incalculable flaws in the assumptions and work of Dunbar and her associates, and the status quo continued to prevail". I would suggest that in holding firm to the status quo, the ideology of mind-body dualism was still explicitly entrenched.

Kunzendorf (1990:147) tells us that historically, efforts to relate physical health to anything mental have been resisted by the scientific and medical establishment.

The tenacity of this resistance is illustrated by the following historical case study of a soldier who died from fright, as an enemy cannon ball passed right before his eyes--without touching him. Because the medical examiners refused to believe that this soldier's death could have been caused by a mental variable like fright, they concluded that the wind of the cannon ball had sucked the air out of his lungs.

Moreover, Kunzendorf (1990:147) argues that their resistance to mentally induced illnesses is superseded by their resistance to mentally induced cures: "To this day, many medical researchers assert that mental imaging can have a curative effect only on illnesses that are imaginary or

psychosomatic, not on diseases that are physical in origin".

In summary, in this section I have outlined the major tenets of biomedicine, with an emphasis on the development of its premise of mind-body dualism. As well, I have presented the current understanding mind-body dualism within biomedicine: how mind has become to be identified with brain, how it offers only an implicit recognition of the impact of the mind on the body through its understanding of the placebo effect and its category of psychosomatic illness. Furthermore, I have illustrated the tenacity with which Western medicine has clung to its notion of the dualistic nature of mind and body in my presentation of the medical community's rejection of Selye's and Dunbar's work on stress and psychosomatic illness, as well as my account of the soldier who, within biomedical understanding, died from having the air sucked out of his lungs by the cannon ball.

Yet, in the following section I will show how developments and changes both from within and as well as outside Western medicine over the past twenty years are attempting to breach its dualism of body and mind, as well as its reductionist epistemology. In doing so, I will track some of the developments which have and are working to modify this tenet and epistemology.

2. Biomedicine: Challenges for Change

In this section I discuss the developments which I suggest are contributing to changes in biomedical beliefs and practices, focusing primarily on the changes within its concept of mind-body dualism. Thus, I discuss the development within biomedicine, of the relatively new discipline, psychoneuroimmunology, as well as the phenomenon of biofeedback. In addition, I describe a discovery within the discipline of neuroscience which has challenged biomedical scientists' understanding of the relationship between mind and body. I examine pressures external to biomedicine which are challenging its beliefs and practices. In this instance, I outline types of alternative of medicine which biomedicine, by and large, views as its rivals. Persistent, insistent, they have emerged in recent years, demanding to be accepted as legitimate options for those who seek medical help. Inherent to many of the beliefs and practices within these alternative systems is the absence of the dualistic nature of body and mind and the presence of a holistic rather than a reductionist approach to the diagnosis and treatment of illness.

Looking outside the medical field, I discuss briefly, the field of quantum physics and outline David Bohm's theory of 'meaning as being' in which he argues that the distinction between mind and body is based on a misguided understanding of the phenomenal world. And finally, I present an extensive examination of visualization therapy which I have proposed is a manifestation cultural of change in the West's model of health and disease.

a. Psychoneuroimmunology

Psychoneuroimmunology, a relatively new discipline within biomedicine, is making a strong challenge to the healing of the mind-body dualism of Western medicine. Psychoneuroimmunology (PNI) is the "academic study of the new-found body-mind connections between psychological states and the neurological, endocrine, and immune systems"(Lerner,1994:137). As a discipline, it emerged in the mid 1970's in response to the observed links between the central nervous system and immunity. For example, the experience of bereavement or marital separation was found to depress the immune system(Rosenbaum,1989:22).

Prior to this time, the accepted wisdom within biomedicine was that the body's immune system which defends the body against disease and infection, as well as maintaining a healthy status quo biochemically, was thought to be totally self-contained and outside the influence of any other system in the body (Locke and Colligan,1986:16-22,26).

In its study of these connections between the mind and emotions, the central nervous system, the autonomic nervous system and the immune system, PNI has found that these systems are highly integrated, highly communicative. They "mutually regulate various aspects of each other's responsiveness and together contribute to the organism's homeostasis"(Gorman and Locke,1989:115). Brigham (1994:17) states that research has shown these systems communicate in two ways: through 'hard-wired' communication between brain and body (neurons) and by 'soft-wiring' through the chemicals such as neuropeptides and other neurotransmitters. Moreover, these chemicals in the brain which control our moods, actions, and perceptions are made not only by the brain but also by the immune system(as well as other systems of the body). Brigham(1994:16-17) concludes that

this means that we have a clearly established cybernetic feedback

loop between the central nervous system and the immune and other systems of the body. As a result, not only do psychological/emotional/eidetic states affect the systems of the body in this loop, but the systems of the body in turn influence psychological states.

In his investigation of how the mind may influence the body in terms of health or disease, Hall(1990:203) notes that

The emerging field of psychoneuroimmunology (PNI) has provided evidence that psychosocial factors have a *bi-directional* influence on a number of immune measures and the immune response; that is, these variables have been associated with either a suppression or an enhancement of immune functioning. This influence of psychosocial factors on immunity is consistent with the view that psychological variables may be associated both with physical illness and with the recovery from disease, and is complemented by evidence that various autonomic physiologic activities are capable of voluntary self-regulation through such procedures as meditation, hypnosis, relaxation, imagery, biofeedback, autogenic training. The possibility that psychological variables may exert a bi-directional influence on immunity has important implications for the self-regulation of biological systems.

Yet, research in this field has focused primarily on factors which suppress rather than enhance the immune system. It has documented how distressing events and affective states such as depression may be linked with physical illness, as well as diminished measures of immune response. In biomedicine's second edition of *Psychoneuroimmunology*, published in 1991, Felten admonishes his medical colleagues for their lack of attention to the impact of positive psychological variables on health. Felten(1991:117) states: "Unfortunately little attention has been given to scientific examination of the counterpart, namely, that positive emotions may contribute to beneficial outcomes and enhanced immune responsiveness". He (1991:1118) asks the question:

Can patients contribute to their own health via neural-immune signaling? Can laughter, strong personal, and social support, determination help the patient to recover from immune mediated disease or protect it from recurring?

His response, based on observation of his patients, is 'possibly' or even 'likely'. Felten(1991:1118) then suggests an important implication of his observation.

If scientific investigation can document the circumstances and mechanisms of these interactions and their applicability to specific diseases, the role of physician will have to be changed to one of a

participant in healing rather than the more traditional role as the initiator or provider of healing in a passive patient. And physicians will have to concern themselves with the health consequences of adverse social and environmental circumstances that might contribute to the deterioration of patients' health.

He(1991:1118) argues that for these reasons "some representatives of the more traditional biomedical establishment cringe at the thought of such implications and try to deny the validity of the entire field". In his reference to the change in the physician's role, I suggest that Felten is calling for an end to the predominately reductionist approach to medical care which has focused on increasingly smaller parts of the physical body to determine the cause of illness. As pointed out earlier in my thesis, Capra argued that it was this approach which marked the end of the concept of healing in medicine because healing implies the recognition of the interplay of psychological, social, environmental and spiritual factors in the onset of illness. This 'cringing' by some of the medical community reflects, I suggest, their reluctance to relinquish one of biomedicine's essential premises: the epistemology of reductionism, and to embrace a more holistic approach in caring for their patients.

Another development which has taken place within biomedicine which is working to seal its tenet of mind-body dualism has been the emergence of biofeedback as part of biomedical practices.

b. Biofeedback

What is biofeedback? Biofeedback is a technique which uses the mind to modify physiological responses such as heart rate, blood pressure, body temperature, brain wave activity and skin temperature(Dossey, 1992:205-6). Specifically, it uses instrumentation to measure and feedback signals of these bodily processes to the patient so that he or she may learn to modify them. As Achterberg(1985:99) states: "The clinical importance of biofeedback is that once the level and minute changes in these function are known, they can be brought under conscious control". Its clinical applications includes the treatment of migraine headaches, Raynaud's syndrome, and cardiovascular disease, especially hypertension(Achterberg,1985:98-99)

Prior to 1969, biomedicine asserted that these bodily responses, under the control of the autonomic nervous were beyond conscious reach, but in 1969 Neal Miller challenged this view, positing that once these functions are

revealed to the conscious mind they can be modified (Brigham, 1994:20). Brigham lauds Miller's biofeedback for its contribution in helping to seal the separation between mind and body. As Brigham (1994:20) states: "Miller's great achievement was to wrest the autonomic nervous system from the brute world of mechanical physiology to its proper place, in the body that has a mind—even if to Miller the mind is brain". With its demonstration that the conscious mind can indeed effect physiological changes, biofeedback has sustained the attack on biomedicine's notion that what happens in the mind has little effect on the body.

Within the field of neurosciences, biochemist Candace Pert and her associates have further challenged this fundamental biomedical premise of mind-body dualism.

c.Neuroscience: Neuropeptides

According to Brigham, biochemist Candace Pert dramatically opened the doors separating body and mind with her identification of the neuropeptides, the chemical messengers of emotion which are produced in the brain but have receptor sites in many parts of the body. In her research of the brain, Pert found receptor sites for these neuropeptides, virtually in every system of the body including the gut and the immune system. Prior to her research, Pert presumed that emotions were in the head or in the brain (Pert, 1986:12). However, with her discovery of these receptor sites she concluded that emotions are expressed in the body and are part of the body (Pert, 1986:12). As a result, Pert no longer thought in dualistic terms when thinking of mind and body. As she (1986:9) stated:

I believe that the neuropeptides and their receptors are a key to understanding how mind and body are interconnected and how emotions can be manifested throughout the body. Indeed, the more we know about neuropeptides, the harder it is to think in the traditional terms of a mind and a body. It makes more sense to speak of a single integrated entity, a 'bodymind'.

In conjunction with psychoneuroimmunology, biofeedback, and the discovery of mind-like qualities in the immune system and the human gut, one of the strongest challenges to the beliefs and practices of biomedicine, including its notion of mind-body dualism has come from the alternative systems of medicine which have emerged within popular western culture over

the past fifteen years.

d. The Alternative Systems of Medicine

Capra states(1988:125-26) that all societies have in place a system of popular medicine which incorporates "beliefs and practices used within a family or community and do not require the professional healers". Yet, in conjunction with this type of medicine, many North American individuals, in addition to using this form of medicine, are actively working for change in their three hundred year old system of medicine. Stimulated by their dissatisfaction, as well as the inadequacies which they see as existing within biomedicine, they are nurturing and supporting parallel systems of medicine incorporating a variety of beliefs and practices, which have emerged outside the mainstream biomedical model. Eisenberg et al(1993:246) define these alternative or complementary systems as those medical interventions which are not taught widely at medical schools or generally available at hospitals nor do they conform with the standards of the medical community. Over the past decade, practices within this complementary health care system have burgeoned. Chisholm (1995:34) asserts that in Canada

only a decade ago, such alternatives were widely viewed as far out on the medical fringe, tainted by allegations of ineffectiveness or, worse, outright quackery. Now, every month seems to bring another book on the subject, while many large drugstores are stocking a wide range of herbal remedies, and holistic health clinics are proliferating across the country(Chisholm1995:34).

In the United States, physician Kronenberg tells us "I think you're seeing an interest in alternative medicine all over the country and consumers are always leading-they leading the physicians, they're leading the reseacher and they're leading the politicians"(McGuire,1995:41). Today, twenty per cent of Canadians consult alternative health practitioners. As well, writing in the *The New England Journal of Medicine*, Vol.328, No.4, Jan. 28, 1993, Eisenberg tells us that in a 1990 survey which looked at the use of unconventional therapies in the United States, one in three Americans used some form of alternative therapy and of these one third saw providers for unconventional therapy(Eisenberg et al,1993:246-252). Kronenberg offers some reasons for this shift in the public's medical practices:

I think consumers are frustrated with the answers that they are not

finding in traditional medicine. Western medicine is wonderful for acute problems but there are a lot of problems for which we don't have answers in this country, yet many other cultures and traditions have some different approaches that are reportedly very effective (McGuire, 1995:41).

In her statement, Kronenberg emphasizes that this change is consumer driven.

Alternative medicines consists of a broad spectrum of practices and beliefs, including homeopathy, acupuncture, chiropractic, herbal medicine, reflexology, aromatherapy, and therapeutic touch (Chisholm, 1995:36-37). Inherent to these practices is a holistic, rather than a reductionist approach. As well, many of these health practices derive from a system which does not separate mind from body. For example, a homeopathic practitioner states that "homeopathic medicine never perceived the mind and body as separate, so it never went down the tracks of conventional medicine" (Riley, 1995:67). Also, acupuncture which is derived from Chinese medicine is based on the idea that the mind, body and spirit are intimately interconnected and interact with one another (Rubick, 1995:41).

Melten (1991:3) suggests that this parallel system of alternative medicines was developed as part of a broader transformation within western culture brought about by the New Age movement, an international social movement which emerged as a force for social transformation in western culture in the 1960's. Melten (1991:3) states that "one prominent model for that transformation, is healing which has given rise to what is possibly the largest identifiable segment of the movement, the holistic health movement".

The reaction of the medical establishment has been by and large, a rejection of these systems of medicine. As Rubick states "acupuncture and other complementary medical modalities that involve holistic principles challenge the dominant biomedical paradigm of mechanical reductionism and therefore are considered unconventional or alternative" (Rubick, 1995:41). Even those, or perhaps especially those physicians who offer alternative medical modalities, increasingly, are finding themselves under attack by the medical establishment. Although by no means are all physicians in Canada against this system of alternative medicines (especially chiropractic and acupuncture), "in virtually every province, medical licensing authorities- which are administered by MDs- are investigating doctors who offer alternative health care and, in some cases, threatening to revoke their

licenses"(Chisholm,1995:35). Presently, fifteen doctors are facing disciplinary action, at least partly because they are practicing various forms of unconventional medicine(Chisholm,1995:40). Medical colleges who have the power to investigate and discipline members argue that they are taking action only to protect the public from quacks and incompetent physicians. However alternative health practitioners retort that "these colleges have been prodded into action by allergists, respirologists and other specialists who fear that their medical turf is being invaded"(Chisholm,1995:40). More pointedly, LaValley, a Nova Scotia physician who himself endured complaints about his unconventional practice said that

this resistance is about maintaining the power of the medical profession. A small number of doctors who run the profession are trying to restrict choice in health care, and they are not interested in the fact that so many people are getting well and we are saving so much money(Chisholm,1995:35).

Yet there are signs that in Canada, as well as in the United States, that the medical establishment is softening its opposition to these alternative medicines, in response to the public's push for more choice in its health care. For example, the British Columbia Medical Association is forming a committee to deal with issues related to alternative medicine. Similarly, "the University of Alberta in Edmonton, and the Alberta Medical Association recently offered its first continuing education course in alternative medicine"(Chisholm,1995:37). In 1995, the Acupuncture of Canada Institute was federally incorporated to continue the teaching program on acupuncture which had been established in 1974 by the Acupuncture Foundation of Canada(Acupuncture Foundation of Canada Institute Publication,1996:4)). In addition, in 1993, the National Institute of Health which is the United State's leading public institution for medical research established an Office for the Study of Alternative Medicine(Chishom,1995:36). Furthermore, medical journals such as *Alternative Therapies in Health and Medicine*, dedicated to the integration of non-traditional therapies into conventional western medicine are now being published(Brain/Mind,1994:7).

In this discussion, I have shown how developments within biomedicine, as well as the alternative systems of medicine, have influenced, or are, at least challenging biomedicine's understanding of the relationship between body and mind and its reductionist practices, but what are some of the influences

beyond the field of medicine which are challenging these doctrines? One of the challenges to mind-body dualism comes from the domain of quantum physics.

e. Monism of mind and body

Quantum physicist David Bohm rejects the Cartesian notion of mind-body dualism. In his theory of *soma significance* he argues for a monism of body and mind. Defining *soma* as matter (including body) and *significance* as meaning, will, intention, value and purpose, he argues that *soma* and *significance* are two aspects of the same reality, corresponding to the physical and mental. Bohm asserts that there is no mental activity which is separate from a somatic entity, as the term psychosomatic implies. He states that "the soma is significant to the mental side but the mental side is at the same time the activity in the soma(Pylkkanen,1989:26).

In his discussion of the mental aspect of this one reality, meaning plays a fundamental role, In fact according to Bohm, meaning is being.

Meaning is an inherent and essential part of our overall reality, and is not merely a purely abstract and ethereal quality having its existence only in the mind....Or to put it differently, in human life, quite generally, meaning is being....our meanings flow into our being, and because the somatic forms in this being are significant, such being flows back into meaning. Each thus, comes to reflect the other. But ultimately, each is the other.....So meaning and being are separated only in thought, but not in actuality. They are but two aspects of one overall reality(Bohm,1989:51).

In his explanation of the relationship between mind and matter, Bohm takes us into the world of quantum physics. He proposes that a quantum particle such as an electron is surrounded by a field of information which is able to guide the activity of the electron and he suggests that meaning is an inherent part of this field of information; it is essential to what a quantum particle is . This field of information is

not understood in the conventional sense of physics such as energy or electric charge. Instead it is understood as a 'condensed form of meaning which has to be unfolded'(Pylkkanen,1989:23).

Bohm suggests that information, as meaning or 'significance' directs matter. He(1989:62) states that matter such as biological processes

are produced when a significance informs energy. So according to

this picture, matter is not a dead thing. Its not anything like billard-balls pushing each other around. Rather, its structure and form is organized by an active meaning, meaning acting within energy.

This notion that meaning, as an integral part of this quantum particle somehow guides its actions, fundamentally alters our conceptualization of the relationship between mind and matter because if there is a mental dimension to all levels of matter, there is no longer a division between mind and matter; they are one entity. At the same time Bohm is quick to point out that this notion does not mean that he is attributing consciousness as we know it, to matter such as sticks and stones(Pylkkanen,1989:22).

In assessing biomedicine's response to quantum physics proposal of a monism of the mental and physical world, Rubik(1995:43) states: "Because of the apparent success of the reductionist paradigm in biology and medicine in recent decades, thanks to strong financial support, the new physics has hardly permeated conventional biology or medicine".

Having explored the development of phenomena which I suggest challenges western biomedicine's theoretical framework, I now present an extensive examination of the use of visual imagery in western culture, firstly by contextualizing its use within western culture itself, and then by exploring, more intensively, its therapeutic use in the treatment of cancer and arthritis.

3. Visualizations.

Imagery is a window on your world; a way of viewing your own ideas, feelings and interpretations. But it is more than a mere window-it is a means of transformation and liberation from distortion in this realm that may unconsciously direct your life and shape your health(Lerner,1994:167).

In this final section of this chapter, I discuss the use of visual imagery in the treatment of physical disease. Although I focus on its use as a force for physical healing, initially I situate it within the wider context of Western culture by considering how it is conceptualized outside the domain of health. Thus, I relate my experiences and observations with regard to imagery when I attended a conference entitled *Mental Training in Excellence*, held here in Ottawa, May 25-29, 1995. As well, I discuss imagery as it is used in childbirth. Briefly too, I examine the phenomenon of neurolinguistic programming which examines the role of visual imagery in cognition and communication. Continuing, I describe neurophysiologist Pribram's theory of how images are

stored in the brain. In conclusion, I discuss psychologist Finke's theory of functional equivalence which offers an explanation of the relationship between image and percept.

Following these discussions, I return to the domain of health and explore psychiatry's and psychology's understanding of visual imagery in its role as therapy. Then, I begin my examination of how visual imagery is conceptualized and practiced in the treatment of physical disease, focusing on its use in the treatment of cancer and arthritis.

Having outlined the format of this chapter, I begin by defining the term imagery. As well, I establish the type of imagery which will be the focus of my thesis. Achterberg(1985:3) defines imagery as

the thought process that invokes and uses the senses: vision, audition, smell, taste, the senses of movement, position and touch. It is the communication mechanism between perception, emotion, and bodily change.

Similarly, Brigham's definition of imagery includes these sensory pathways. She states that "imagery involves all sensory channels-sight, sound, touch, kinetics, taste, smell and what Dr. Eugene Gendlin call 'the felt sense'(Brigham,1994:35). She adds, that although our particular culture is especially attached to the visual sense of imagery, visualizing is only one aspect, the one that deals primarily with the sensory modality of sight rather than the totality of sensory information(Brigham,1994:35,128).

In answer to the question, what is mental imagery, Epstein(1989:3) replies, "Simply put, it is the mind thinking in pictures". McMahon and Sheikh(1986:27) offer their definition: "Mental imagery refers to all those quasi-sensory or quasi-perceptual experiences of which we are self-consciously aware, and which exist for us in the absence of those stimulus conditions that are known to produce their genuine sensory or perceptual counterparts".

Lerner(1994:167) tells us that

imagery is a flow of thoughts you can see, hear, feel, smell or taste. An image is an inner representation of your experience or your fantasies- a way your mind codes, stores and expresses information. Imagery is the currency of dreams and daydreams; memories and reminiscence; plans, projections, and possibilities. It is the language of the arts, the emotions and most important of the deep inner self.

Finally, and poetically, Gerrard states:

Visualization is the other side of human nature, the primitive darkness, the energizing non-rational flow, the connection to the Source, the artist's inspiration, the path in the right hemisphere of the brain, the Dionysus to civilization's Appolonian rigidity, the door to the fountainhead. Visualization is not just an idea; it is one half of consciousness. It is one way we think, perhaps the more basic way(Samuels,1975:xii).

Reflecting the bias of my culture for visual imagery, I have, as I discussed in the introduction of my thesis, chosen to focus on the use of visual imagery as a therapeutic modality. I have done so because my initial introduction and attraction to imagery in healing was stimulated by the work done in the 1970s by the Simontons' with regard to the use of visualizations in the treatment of cancer(Simontons,1978:3-260). It will become clear though through my discussion of criteria and guidelines for imagery work in healing that today, imagery as therapy has moved beyond the use of the sensory mode of sight to include other sensory channels as mentioned in the above definitions of imagery. Having discussed visual imagery in terms of its definition, I now explore its use in North American culture.

The Use of Visual Imagery in Western Culture.

Visualizations play a role outside the domain of health, as I discovered when I attended a world congress entitled *Mental Training in Excellence*, held here in Ottawa, May 25-29, 1995. This congress explored how individuals may enhance their performance skills in areas such as dance, music and sports, using mental skills including visual imagery. Allow me to elaborate from my own personal experience....

...Lying on a conference room floor, along with thirty other people, I was instructed to mentally pick off the muscles and tendons from my bones until I had hollow skin around them. Then, I was asked to 'empty out' my bones, and fill up my body with a colour of my choice(bright yellow) and to note its effect on my mental state and on my movements, as I moved about the room. This guided imagery session took place in a workshop on imagery and dance, as an illustration of one of the types of imagery used to induce mind states which enhance dance performance. According to Christine Hanrahan(personal communication,May 25,1996) who ran the workshop, the purpose of this particular imagery was to empty the body of undesired energy

and to release and unblock parts of the body. Filling up the body with a colour would inspire a desired sensation, movement dynamic or emotion(Hanrahan, n.d.: table 5 and 6). When I asked her at what point in time dancers started using imagery to heighten their performances, she laughed and said "since prehistoric times", but estimated that using specific imagery in a systematic way began approximately fifteen years ago.

The sports world also uses visualizations to attain peak performances. They are used in a variety of sports, including olympic sports of all kind: elite hockey, baseball, and marathon runners. I listened to NHL goalie, Craig Billington describe his pre- performance imagery: Arriving at the rink well ahead of game time, he goes behind the goal where he envisions himself making saves. He sees players coming at him. Sometimes it is a specific person coming at him, sometimes not. He creates these images from both an external and internal perspective. He says that he already has "put images in my brain, therefore I don't have to do it again on the ice....By game time, he says that"[he] just plays,... feels like my brain has "clicked off", automated, not the thinking part,...just plays" (Billington, May 26,1995: panel discussion).

In conversation with marathon runner Shirley Kay Durtschi, she told me that in her training for a marathon with sixteen thousand other runners, she visualized herself as running in the eye of a needle. Because she had done this visualization so many times during her training, that when she began to race, like Billington, she had no thoughts; she just ran. She was aware of nothing else, just running....(personal communication,May 26,1995:in conversation).

Brigham(1994:33) offers an explanation for these experiences. She asserts that the body does not know the difference between an actual event and an eidetic one. Thus, mental practice has the same effect as actual practice. Jacobsen has provided evidence of this link between mental and physical events:

In 1929 physiologist Jacobsen showed that just by thinking about a particular body movement, the appropriate motor neurons are activated. To be sure, the rate of firing is extremely low, and muscle activity is perceptible only with sensitive recording instruments. Nevertheless, thinking about swinging a golf club actually triggers those muscles to become active. The swing is rehearsed and perfected in just this fashion-- a well-established practice among professional athletes(Achterberg,1985:114).

In addition, visualizations have a role to play in pregnancy and labour, according to Carl Jones, a certified childbirth educator. Jones argues that the experience of childbirth is an event of the mind, as well as the body and that by using visualizations and other mental imagery, the fear and pain of childbirth can be reduced. He bases his understanding of how imagery accomplishes this goal on biofeedback research which has shown that one can learn to control involuntary bodily processes by forming relaxing images in the mind (Jones, 1987:4). When asked how mental imagery is so effective in pregnancy and labour, his response was that it creates a smoother labour by promoting deep relaxation, helping the mother to surrender to the process, and facilitating the release of labour-regulating hormones (Jones, 1987:13). According to Jones, visualizations, such as imagining a flower, opening petal by petal during labour, induces the release of these hormones which cause the cervix to dilate and the birth canal to open (Jones, 1987:4-10, 142). The outcome is a "less physically traumatic birth and more pain free delivery; and less need for instrumentation, and use of anesthetic agents" (Jones, 1987:12).

Visual imagery also may play a role in thinking and communication, according to Bandler and Grinder (Bandler and Grinder, 1979:14-15). These two individuals present a model of human communication and experience called neurolinguistic programming which proposes that people think and communicate predominately in one of three representational systems, corresponding to the three principle senses: that of vision, hearing and feeling (kinesthetic) (Bandler and Grinder, 1979:14-15). For example, those who think visually will generate visual images in their thinking processes while those who think auditorily will talk to themselves or hear sounds. According to Bandler and Grinder, one can discover which system a person is using by listening to the kinds of predicates: verbs, adverbs and adjectives that the person uses to describe his or her experience (Bandler and Grinder, 1979:14-15). For instance, the visual thinker may use words such as "Sure. I can see what you are talking about" or "Tell me how it is you see your situation right now" while the kinesthetic thinker may use words such as "I think maybe I did something wrong but I just can't get a grasp on what it was" or "my life has a lot of rough edges" (Bandler and Grinder, 1979:10-11).

Another way of accessing people's representation system is to follow their eye movements: "people make movements with their eyes which indicate

to you which representational system they are using"(Bandler and Grinder,1979:18). By learning how an individual thinks and communicates, one may use this knowledge to modify or reinforce any sequence of behaviour which one observes in a person(Dilts, Grinder, Bandler, Bandler and DeLozier,1980:3).

In his conceptualization of visual imagery, neuroscientist Karl Pribram draws an analogy between how the brain stores and retrieves images, to the operation of a hologram. Pribram asserts that the brain's structure is holographic and that images, as well as other mental contents do not reside in a particular part of the brain. Rather, they become distributed throughout the entire system. In a hologram, stored information about forms in space becomes distributed and blurred over the entire extent of the holographic film but in such a precise fashion that it can be deblurred by performing the inverse procedure. With the aid of sensory stimuli from the environment, via the structures of local brain circuitry, images and mental events emerge and are reconstructed(Pribram,1986:514;Brigham,1994:31). As Pribram(1986:14) states:

Thus, the image reconstruction(or construction) from the stored spectral domain in the brain is simple; applying the same transform that produced the store will also decode it into an image....Either an input from the senses or from some central source(such as the pain pleasure expectation and attention mechanisms) will activate the spectrally encoded memory trace to produce an image.

In his exploration of visual imagery, Finke examines the relationship between image and perception. In his theory of functional equivalence, he argues that image and percept are experientially and neurophysiologically similar processes(McMahon, and Sheikh,1986:24). Finke proposes that

mental images can stimulate visual processing mechanisms directly. Thus, when mental images are formed, these mechanisms would respond in much the same way as they do when objects and events are observe, resulting in the sensation that an image can be seen as if it were an actual object or event. Further the more vivid the image, the more strongly these mechanisms would respond, and the more similar to actual objects or events the mental image would appear(Noll,1985:446).

Having surveyed the use of visualizations outside the domain of health, I now return to the health field and examine how psychiatry and psychology

conceptualize visualizations.

Psychology's and Psychiatry's Conceptualization of Visual Imagery.

According to Nancy and Mike Samuels (1975:34), "up until the early 20th century, the science of psychology had accepted as self evident the validity and existence of images and inner experiences". However, by the mid twentieth century, for a majority of North American psychologists, mental imagery (which included visual imagery) did not exist. Grippled in the behaviourist paradigm which discarded references to mind or psyche as useful categories to understand human nature, it focused instead on the study of behaviour, using scientific methodology based on observation and experimentation (Crapps, 1986:95-96). As behaviourist Skinner stated bluntly: "We do not need to discover what personalities, states of mind, feelings, traits of character, plans, purpose, intentions, or other prerequisites of autonomous man really are, in order to get on with a scientific analysis of behaviour." (Crapps, 1986:96).

However, by the 1960's, interest in mental imagery re-emerged, stimulated by developments outside mainstream psychology. One of these areas which rekindled psychology's interest in exploring the mind was the New Age movement. This social movement emerged in the 1960s to become a force for change in areas such as psychology and medicine. Grounded historically in an occult-psychic-metaphysical tradition, it emerged in response to a call for personal and social transformation within western culture. In psychology, it expressed itself in the reawakening of an interest in phenomenon of the mind (Melton, 1991:ix-4).

Other events also refocused psychology's attention on mental events. Holt (1964:257-8) suggests that studies of political prisoners of war who spent long periods of time in isolation during which they experienced pseudo-hallucinatory imagery, as well as the use of hallucinogenic drugs by groups within the general population helped to reawaken interest in mental imagery.

By the 1970s imagery had become a major focus of research (Smith, 1990:216). McMahon and Sheikh (1986:27) stated: "From a position of near disgrace, imagery recently has risen to be one of the hottest issues in both clinical and experimental cognitive psychology".

Numerous psychological therapies now use imagery as a therapeutic tool. For example, psychologists use imagery to gain access to memories formed during the developmental stage before language was present or not yet predominant (McMahon and Sheikh, 1986:25). Also, images may elicit repressed events. Research has shown that " 'free imagery' which is analogous to free association, is highly effective in circumventing even stubborn defenses and bringing to light repressed material"(McMahon and Sheikh,1986:25).

Today, some psychiatrists include visual imagery in their practices. For instance, imagery is a strong component of psychiatrist Stanislav Grof's holotropic therapy. In this type of therapy, non-ordinary states of consciousness are induced, including transpersonal dimensions in which an individual's consciousness extends beyond the boundaries of the body-ego, time and space(Grof,1988:38). During these states of consciousness, participants may experience powerful imagery. Indeed, in the transpersonal domains individuals *become* their image. For example, one participant while in this state of consciousness, experienced himself as an eagle with its particular sense of vision(Grof,1988:55). In another instance a woman, in a more ego bound state of consciousness, envisioned an image of a black water bird which calmly dived under huge ocean waves but, always reappeared on the surface. She says:

I held to the image that I was like that water bird; that the only safety for me lay in diving deeper. I kept going, releasing hold on ordinary identity, letting go of thinking, fears, ideas, members of my family, other supports.... After some twenty to twenty-five minutes(as I judged later), I was fully into the process. Whatever my body seemed to want to do, I let it do it(Grof,1988:214).

Grof(1988:167) argues that in these altered states of consciousness,

the human psyche seems to show spontaneous healing activity... This tends to change the dynamic equilibrium underlying symptoms, transform them into a stream of unusual experiences, and consume them in the process.

Imagery is also an inherent part of psychotherapist Eugene Gendlin's technique of focusing. According to Gendlin(1979:ix), the body is an incredible reservoir of self- knowledge. By using his technique of focusing one may tap into this bodily mode of knowledge and gain insights into problems or events which are not accessible through intellectual, analytical or rational modes of

knowing. Images, as well as words or phrases act to transpose self knowledge from the body to the conscious mind or from the mind to body. As a result of the insights achieved, one has the potential to make oneself psychologically and emotionally healthy(Gendlin,1979:ix-11).

Another psychiatrist who placed great importance on imagery, including visual imagery, was Carl Jung. According to Jung, imagery is the language of communication between the unconscious and conscious mind. He states: "Certain patterns deep within the unconscious, partially reveal themselves through dreams, fantasies, creative works in bigger than life images which can have specific awesome quality"(Sawyer:1986:395). These images bring potent messages from the unconscious realm to the conscious realm so that the individual remains psychologically whole(Jung,1968:34). For example, through dream imagery, the unconscious aspect of an event is relayed to us where it manifests

not as a rational thought but as a symbolic image....These symbolic images express specific messages to the conscious mind. These images are compensatory and can bring powerful new revelations to the conscious mind. In this way these symbolic dream images function to re-establish, in a subtle way, the total psychic equilibrium. This is what I call the complementary (or compensatory) role of dreams in our psychic make-up(Jung,1968:4,34).

Moreover, Jung(1968:37) argues that if these two psychological realms do not communicate, and become "dissociated" then psychological disturbance occurs.

Having surveyed various psychological and psychiatric perspectives on visual imagery, I now examine how visual imagery is conceptualized and practiced in the treatment of physical disease. I consider briefly, the history of visualization techniques in biomedicine. Then, I discuss those illnesses which advocates of visualization therapy suggest may be helped by visualizations. Continuing, I present an intensive examination of how visualization therapy is conceptualized and practiced by its advocates in the treatment of physical disease. In the concluding part of this section on visualization therapy, I discuss its use in the treatment of cancer and arthritis.

Visualization therapy in the Treatment of Physical Disease.

Visualization techniques have been used in European western medicine since the early part of the 20th century(Samuels,1975:223). At that time, Schultz, a German physician developed a self healing technique called

autogenic therapy. Its purpose was to evoke inherent physiological processes which would help to restore the body to a state of health, that is "to facilitate autogenic (brain directed, self-generating, self-regulatory) processes of a self-normalizing nature...which normally participate in homeostatic, recuperative...processes"(Samuels,1975:223).

Autogenic therapy uses a series of standardized exercises to evoke these healing processes, including relaxation, autosuggestion and visualization exercises. It is used to treat a variety of diseases, including asthma, gastritis, ulcers, angina, high blood pressure, headaches, diabetes, arthritis, low back pain(Samuels,1975:34; Achterberg,1985:88).

The Samuels state that extensive research has been done which demonstrates the efficacy of autogenic therapy in the treatment of a number of chronic diseases. As an example, in one case study Dr. Schultz had a patient with excessive gastric secretion gaze at the texture and dryness of blotting paper and imagine "absorbent dryness. Tests showed that the patient's excessive secretion, normalized within ten days of using these visualizations(Samuels,1975:225).

Currently, visualizations are used extensively, according to those health practitioners who promote its use as a means of healing. In his book *Healing with Imagery*, psychiatrist Epstein offers visualization exercises for seventy-five physical and mental disturbances such as asthma, coronary artery disease, eczema, headaches, grief, depression, and even the common cold! In attributing the power of mental imagery to affect physiological changes, Epstein argues that it is only problematic for those who think in dualistic terms. He(1989:4) states that

the beneficial physical effects of imagery would not be so surprising if we commonly thought of the mental and physical aspects as comprising two sides of a mirror that we term 'body'. But for three hundred years Western medicine has separated the mind from the body.

Similarly, in her book *Imagery in Healing*, Achterberg(1985:101) tells us that visualization therapy has been used and "validated on patients having chronic pain, rheumatoid arthritis, cancer, diabetes, severe orthopedic trauma...alcoholism and stress-related disorders such as migraine headaches and hypertension".

Brigham's book *Imagery for Getting Well*, advocates the use of imagery

(including visualizations) for illnesses such as "cancer...cardiovascular disease, multiple sclerosis, chronic pain, systemic lupus, HIV disease, rheumatoid arthritis, neurological dysfunctions, gastrointestinal disorders, and diabetes"(Brigham,1994:37).

Naparstek, who in her book *Staying Well with Guided Imagery*, presents her reader with a series of guided imagery for a variety of illnesses, suggesting that visual imageries and other types of imageries not only aid in the healing process but they also have the potential to keep us well(Naparstek,1994:12). Naparstek has produced a series of audiotapes on imagery for a variety of diseases, called *Health Journeys*. Included in this series, is one for keeping well. She observed that the interest in simple wellness imagery was enormous. "People were eager to know how to use imagery to maintain their good health, reduce affects of stress and prevent problems *before they began*"(Naparstek,1994:12-13).

To illustrate the effectiveness of visual imagery in bringing someone back to a state of health, visualization therapists cite various studies. Achterberg presents her study on the use of visualizations for burn patients, as an example of its effectiveness. This study showed that those patients who received relaxation and imagery exercises required significantly fewer pain medications and sedatives, and had less muscle tension than those patients who did not(Achterberg,1985:108-111).

As an example of prevention in the onset of physical symptoms, Naparstek cites the study in which eighty four per cent of the participants who used imagery, under hypnosis, eliminated the standard histamine response to poison ivy: itching, redness, swelling, and blisters, when they imagined the poison ivy to be a harmless plant(Naparstek,1994:19).

Furthermore, according to physician Brian Morris, visual imagery has been used successfully, to treat warts. Morris presents his case study in which a ten year old girl with a three year history warts on her hands, responded successfully to visualization techniques, in conjunction with hypnosis(Morris,1985:238-240). Finally, Naparstek(1993:20) informs us that anaesthetists Hord and Sebel showed that in a study of sixty patients those who received guided imagery during surgery required less pain medication (morphine) than those who did not.

In addition to its effectiveness in healing, Achterberg argues that

visual imagery has prognostic abilities. She and her husband Lawlis developed a test, the Image-CA which revealed that disease imagery is a better predictor of disease status than blood chemistry (Brigham, 1994:38; Pelton and Overholser, 1994:235). Schneider et al (1990:180) state that

in this test the patients learn to image their cancer, their immune system and their treatment. Afterwards, they are asked to draw pictures of these aspects of the imagery, and to respond to a structured interview designed to elicit a verbal description. The imagery is rated on 14 dimensions thought to reflect the patients' attitudes about the virulence of their cancer and the efficacy of their immune system and medical treatment against cancer. This procedure yields a final score that reflects what Achterberg and Lawlis call 'quality of disease-related imagery'.

In three separate studies, three hundred patients were interviewed and evaluated. In those cases where patients died or their condition deteriorated, the evaluation of their images predicted the course of their disease with 100% accuracy. For those who entered remission, their test score predicted improvement with 93% accuracy (Pelton and Overholser, 1994:235).

In summary, we know that visual imagery is used for a myriad of physical and mental illnesses. We also have an idea of its effectiveness in healing, according to its advocates. Yet the question arises, how do these advocates of visualizations and other types of imagery, explain the physiological effects of imagery? How do they explain the link between imagery, health and disease? The answer: they root their understanding of these effects and the link between imagery and healing in the discipline of psychoneuroimmunology.

Theoretical Basis of Visualization Therapy

As discussed earlier in my thesis, the field of psychoneuroimmunology has demonstrated the interconnections and interregulatory actions between the central nervous system, the endocrine system and immune system. As Hall has stated, psychosocial and cognitive variables have been shown to suppress or enhance immune functioning and therefore may be associated both in the onset, and in the recovery from physical illness. Imagery therapists who seek to explain how the image may effect beneficial physiological changes, do so within this psychoneuroimmunological framework. For example, Naparstek (1994:209) states that "images appear to activate the nervous system,

sending neurohormones(chemical messengers) through the bloodstream to specific cells, where they trigger healing activity".

Elaborating, Drs. Elmer and Alyce Green propose that

perception(or imagery) elicits mental and emotional responses which generate chemical responses in the limbic system (*the brain's processing area of emotions*), thus, activating the pituitary(*endocrine*) and bringing about physiological responses. These physiological responses are then perceived and responded to, in turn, completing a cybernetic feedback loop(Brigham,1994:17).

As well, Brigham, who includes imagery in her twenty-eight day behavioural medicine program, designed to help people to regain their health, also bases it on psychoneuroimmunological principles. She argues that by changing our images, our thoughts, and beliefs we can alter the functioning and chemistry of our body in the direction of health; images can be a blueprint for health.

She(1994:127) states:

We accept the hypothesis that imagery is the blue print for all voluntary behaviours and exerts a preeminent influence on involuntary physical, emotional and mental behaviours. Imagery takes place all the time in the individual, whether at a at conscious or unconscious level. Images may provide healthy blueprints for one's life and body, or they may supply destructive designs for body and spirit.

Within the field of psychoneuroimmunology, studies have been done which looked at the influence of the image on the immune system. For instance, Schneider and his associates conducted a study, showing that images are capable of influencing aspects of the immune system. The purpose of this study was "to show the relationship between a mental process (i.e. imagery) and changes in function of a particular type of white blood cell (neutrophil)"(Schneider et al,1990:179-191). Schneider's study showed that, indeed, individuals could modify the actions of this cell which is part of the immune system, through imagery. During the study, subjects were given lectures on the immune system and received training in imagery techniques. Blood samples were taken prior to their imagery sessions. They were then asked to imagine their neutrophils responding as if there was a crisis, meaning that the neutrophils should leave the blood stream. Blood samples taken after the imagery session, showed that, in fact, "sixty per cent of all the

neutrophils were missing in this post session blood sample"(Schneider et al,1990:184). Thus, Schneider and his associates provided evidence of the image's influence on the immune system.

As well as considering psychoneuroimmunology as the theoretical basis to understand the links between imagery, health and disease, Achterberg examines the physiological correlates of the image in order to understand its impact on the body.

In considering the physiological correlates of the image, Achterberg offers the example of phobic imagery which engenders dramatic physiological changes. Achterberg(1985:114)states that "imaging noxious stimuli has been associated with physiological arousal as measured by heart rate, muscle tension, and skin resistance levels". Moreover, individuals who experience very vivid imagery may have full blown physiological responses. As an example, she relates the account of a man "who was able to increase his heart rate by imagining himself running, and who could alter the size of his pupils and manipulate his cochlear reflex by imaging sights and sounds"(Achterberg,1985:114).

Furthermore, Achterberg suggests that research reveals " that images affect physical reactions directly and indirectly, and, in turn, are affected by those reactions. In addition, images may either precede or follow physiological changes, indicating both a causative and reactive role(Achterberg,1985:115).

In conjunction with basing her understanding of the physiological effects of the image on psychoneuroimmunological principles, Naparstek adopts psychologist Finke's theory of functional equivalence to enhance her understanding of its impact on the body. She argues that our bodies don't discriminate between sensory images in the mind and the original event. Naparstek(1993:18) states: "With a sensory image, echoes of the mood, emotions, physiological state, and blood chemistry associated with the original event, reverberate in the body". As an example, she(1993:18; states that "the body is just as enthusiastic about sexual fantasy as reality...; it responds as if the images were actual events".

Having gained some understanding of the theoretical foundation upon which imagery is based by those who use it clinically, I now consider the criteria and guidelines upon which imagery therapists base their practice.

Guidelines and Criteria for the Practice of Visual Imagery

In considering the guidelines and criteria for the practice of visualizations, several questions arise. Is relaxation a prerequisite for doing visualizations? Is imagery more effective when experienced in an altered state? Should treatment images be physiologically based? Are visualizations the most effective form of imagery in terms of healing? Should imagery be guided or unguided? Are symbolic images more effective than anatomically correct ones? Are images effective if they contravene a person's values? These are some of the questions I consider in my exploration of the clinical aspect of visual imagery.

In terms of methodology, both Brigham and Achterberg emphasize that some form of relaxation exercise is paramount in creating the atmosphere for imagery to be successful. Brigham(1994:128) notes that "many people come into the sessions so physically tense, it is impossible for them to have a good imagery experience". Achterberg(1985:105) adds that a deeply relaxed state prevents bodily sensations, thoughts and external stimuli from interfering with the production of imagery. Naparstek goes even further, arguing that in order to effect beneficial physiological changes, visualizations or other types of imagery, are best done while one is in a state of consciousness, outside of the normal waking consciousness. She(1994:23) maintains that the healing effect is enhanced in this state of

relaxed focus, a kind of calm but energized alertness, a focused reverie. Attention is concentrated on one thing, or on a very narrow band of things.

In these altered states of consciousness, such as those states between wakefulness and sleep, or in meditation, the images experienced are spontaneous, often vivid, detailed and symbolic(Samuels,1975:39-50). Images which come to awareness in this spontaneous manner arise, as Jung has noted, from the unconscious mind as the language through which the unconscious mind communicates to the conscious mind. Often these images are expressed in symbolic form because, as Jung states "there are innumerable things beyond the range of human understanding, we constantly use symbolic terms to represent concepts that we cannot define or fully comprehend"(Samuels,1975:81-82). In this way, imagery experienced in these altered states of consciousness may reveal unconscious meanings of the

disease and its treatment to the patient. As a result of the symbolic and personal nature of images engendered by the patient in these altered states of consciousness, Achterberg argues that individual assessment of the patient's imagery is mandatory in order for imagery to be beneficial in terms of healing. Assessment of the patient's imagery reveals the meaning of the disease and its treatment and, where necessary leads to its modification so that it may be effective. Further in this chapter, I discuss more comprehensively, Achterberg's analysis of imagery, showing how it relates to the treatment of cancer.

Achterberg stresses that treatment imagery must be physiologically correct in order to effect healing. For example, she(1985:107) states that

persons with diabetes often image the high blood sugar as their problem, and imagine that it will be solved if the blood sugar would just leave. In truth, their primary problem is that the mechanism for transporting sugar into the cells and metabolizing it for food is deficient; hence it stays in the blood stream.

Thus, in her view, education about the disease, its treatment, as well as the body's response to treatment is important. Achterberg(1985:103) emphasizes that imagery must be based on realistic expectations of what the body can or cannot do: "There are some things bodies and minds just don't know how to heal yet, and which modern medicine can't help either, such as spinal cord injury".

Naparstek addresses the question as to the kind of imagery used, whether it should be visual, auditory, or kinesthetic and suggests that the individual needs to use the sensory avenue which works best for him or her. Some of us are more auditory or tactile than visual; others of us are more responsive to taste and smell(Naparstek,1994:29). Her suggestion, I propose, reinforces Grinder and Bandler's postulation which I presented earlier in my thesis, that individuals think and communicate predominately in one sensory mode.

Naparstek asserts that there has been an evolution in the use of imagery in clinical practice. She(1994:41) states:

that in the sixties and seventies, imagery was something essentially visual and two-dimensional. Imagery meant flat, disembodied picture produced in the head. One problem with this view was that people who weren't particularly "visual" didn't do well with it; those with auditory and kinesthetic imaginations, for example, were at a disadvantage.

In her view, imagery has come a long way from the days of O. Carl Simonton and his former wife Stephanie Matthews-Simonton who were pioneers in developing imagery for cancer patients and in studying its impact on the disease. She (1994:41) maintains that "we now know that it needs to be a multisensory experience, accessed in the altered state, and probably most effective when felt as sensation in the body". In her view, multisensory, kinesthetic imagery "is far more effective for healing than the flat, strictly visual, two dimensional variety." (Naparstek, 1994:43) It needs to be experienced in the body for maximum for maximum physical and emotional well-being (Naparstek, 1994:41). The value of kinesthetic imagery was discovered in biofeedback techniques in which individuals learned to sense, within their bodies, certain vital functions such as blood pressure and pulse rate. Through this technique people became highly tuned to their bodies and were able to identify internal sensations as never before. In Naparstek's view this ability "provided an essentially missing piece in imagery work: the importance of focusing on how the body feels; the value of kinesthetic imagery." (Naparstek, 1994:42)

Brigham, too, states that her understanding of imagery broadened from the sole use of visualizations in the treatment of patients as espoused by the Simontons, to the use of imagery involving all the senses. She relates the account of one of her cancer patients who did not respond to visualizations, saying that she was an "ear person". This patient was a jazz musician. With Brigham's encouragement, she, in Brigham's words,

created the most extraordinary jazz depiction of the immune system-cancer battle, with the heroic chemotherapy coming through and the tumor growing smaller and smaller. Even better, she started playing her piano again and became involved with the jazz she loved so much. And, yes, Chris's tumour got smaller for many months, and she eventually tripled her prognosis. But best of all, she really started living again (Brigham, 1994:14).

Naparstek adds the criteria of touch and music to imagery sessions, arguing that touch is a most powerful adjunct for increasing the effects of imagery (Naparstek, 1994:40). She (1994:43) states that

it helps direct awareness to the appropriate places inside the body, while making the imagery more intense and powerful at the same time. Putting your hand over your heart and imagining a calm, loving reassurance coming out of the warmth of your hand and into

your chest, suggesting that your heart needn't be in such a hurry, will very likely slow the pulse down to a nice, calm, steady beat.

Listening to music while practicing guided imagery increases its effectiveness, according to Naparstek. Like touch, music works synergistically with the imagery to produce an enhanced effect(Naparstek,1994:36).

In considering the issue of guided versus unguided or spontaneous imagery, imagery therapists offer their views. Naparstek(1994:198) suggests that her clients do guided imagery which she defines as " a kind of directed, deliberate daydream, a purposeful creation of positive sensory images- sights, sounds, smells, tastes, and feel- in your imagination". Unlike Achterberg, her imagery is not based on individual assessment; it is not explicitly individualized. Yet, Naparstek(1994:14) maintains that over time, the patient's imagery shifts and changes, becoming more personal and spontaneous:

Of the scripted imagery, you will find that the images that have meaning to you will come to the fore, while those that are irrelevant fade into the background. It is this interplay between "programmed" and spontaneous" imagery that gets us in touch with the truth of our bodies and the deepest parts of ourselves.

Brigham sees guided imagery as a way of introducing people to the process of imagery, as well as eliminating the frustration and confusion which may result from asking individuals to design their own imagery. Also, guided imagery may give participants "useful images from which they can create their own imagery, as well as a secure handrail on a stairway which eventually will take them where they need to go"(Brigham,1994:136). However, she argues that "the most effective imagery, in the long run, is imagery that the patient has designed for him or herself or that unfolds as it is happening(Brigham,1994:135). In her view, in order that imagery brings positive biological changes

guided imagery must be idiosyncratic and must reflect deep personal meaning and metaphor.... Ready-made visualizations from a therapist or on commercial tapes are of limited value and have a place only where they tap into the unique unconscious desires, preferences, and values of the individual(Brigham,1994:140).

In her imagery work with patients, Brigham and her client explore the problem that has brought the client to her program. Then, she works with this person to generate appropriate imagery; together they plan an expansion of the person's own imagery(Brigham,1994:138). Particularly, she(1994:140)

states that "when the disease is seen as powerful, the power of the metaphor needs to become a therapeutic issue". As Jung(1968:4-5) has observed, symbols are messages from the unconscious to the conscious mind. According to Brigham these symbolic images need to be deciphered and modified if they are negative so that the imagery promotes rather than obstructs the healing process.

In her consideration of the effectiveness of symbolic versus anatomically correct imagery, Achterberg(1985:105) has observed in her practice that the "more symbolic images, as opposed to those that are realistic or anatomically correct, are better predictors of good health outcomes". Brigham concurs with this observation in her statement that imagery must reflect deep personal meaning and metaphor; it must tap into the unconscious desires and values of the individual in order for it to be effective. However, in his book, *Choices in Healing*, Lerner(1994:167) suggests that there is a debate within the field of imagery as to whether or not this observation is valid:

Some clinicians argue that imagery that is anatomically accurate is more powerful than imagery that uses powerful symbolic representations. He states that while not specifically addressing cancer, research studies are divided on this subject. Most clinicians are inclined to believe that symbolic representations can be just as powerful or more powerful for some patients than anatomically accurate ones.

Brigham and Naparstek argue that for imagery to be effective it must be congruent with the patient's value system. Brigham(1994:139) argues that "imagery cannot be effective unless it is in line with the person's deepest values and does not contradict that person's worldview". As Naparstek(1994:33) points out, "you may not feel comfortable with the warlike imagery of natural killer cells annihilating bacteria in your body; you may prefer to focus on other aspects of your immune system, such as the macrophages munching on debris". Yet, Lerner(1994:166) points out that, there is presently a debate among clinicians who use imagery, that aggressive imagery rather than gentle imagery is more effective, despite the fact that this imagery might "be foreign to their personalities and to their sources of inner strength". Achterberg and the Simontons call for this aggressive type of imagery, particularly in the treatment of cancer(Lerner,1994:166).

Both Naparstek and Achterberg insist that imagery requires active participation of the patient. Persons who use visualizations successfully put

considerable energy into their session, more than thirty minutes a day, twice a day(Naparstek,1994:29; Achterberg,1985:107).

In addition to these criteria and guidelines, Achterberg(1985:96) stresses that the patient must conclude his or her visualization session by visualizing him or herself as already healed, thereby avoiding the potential harm that might result from visualizing the healing process incorrectly. She(1985:96) advises us to consider, seriously, this issue: "If specific images can result in a corresponding physical change, then damage may also inadvertently occur". Aside from the possibility of potential harm to the body, this type of imagery helps to create the desired effect of a healthy outcome. As Brigham(1994:141) emphasizes:

For best results the disease image needs to be seen as completely gone and the body perfectly healthy at the end of the imagery session, and the patient should affirm that everything he or she imaged is already in place....In our experience, when the image of mostly gone is left, the message is picked up by the body. In other words, loving one's disease and not wanting to have it completely gone may allow the body to accept the disease and create a pleasant place for it to evolve.

In her imagery work, Brigham insists that it be used in conjunction with biomedical practices. In her view, while imagery such as visualizations may be considered as potent tools for healing, they are not a substitute for medical treatment. Brigham argues that it makes no sense to reject the remarkable advances in medical technology when patients must face life-challenging situations.

In such cases, one must use all the modalities available, from medicine to behavioural tactics to psychosocial strategies to spiritual interventions. There should be no question about using every accessible path and stocking one's armamentarium with every available vehicle for healing(Brigham,1994:58).

Having outlined the general criteria and guidelines upon which health practitioners of visual and other types of imagery base their practices, I now examine its practice in the treatment of cancer and arthritis.

Visualizations in the Treatment of Cancer.

I'd begin to visualize my cancer-as I saw it in my mind's eye. I'd make

a game of it. The cancer would be a snake, a wolverine or some vicious animal. The cure, white husky dogs by the millions. It would be a confrontation of good and evil. I'd envision the dogs grabbing the cancer and shaking it, ripping it to shreds. The forces of good would win. The cancer would shrink- from a big snake to a little snake-and then disappear. Then the white army of dogs would lick up the residue and clean my abdominal cavity until it was spotless." Gilley did this three times a day for 10 to 15 minute intervals. After six weeks of meditation, an examination revealed his tumour had shrunk by 75%. After two months Gilley had a cancer scan. There was not trace of the disease left in his body(Samuels,1975:227).

You have just experienced, vicariously, a sample of a visualization process which has been given by Carl Simonton and his wife Stephanie to many patients over the years. Carl Simonton, an oncologist trained in radiation therapy, and his wife Stephanie, a psychotherapist, are considered pioneers in the use of visualization therapy for cancer patients. They began treating cancer patients with this type of therapy in 1971(Simontons,1978:4-5).

The Simontons(1978:10) argue that the mind plays a role in the cause and the treatment of cancer and, that through visualization therapy physical changes can be effected which can help to eliminate the cancer and return the person with cancer to a healthful state. Carl Simonton maintains that there is abundant evidence in the literature about the role of emotional stress in the onset and development of cancer, arguing that "the question is not whether there is a relationship between emotional stress and cancer but rather what is the precise link"(Capra,1988:152).

In the treatment of cancer, he argues that the belief system of the patient is crucial to the success of the therapy. He and his wife worked hard to reverse the popular notion of cancer. As Simonton outlines:

our image of cancer is that of a powerful invader that strikes the body from outside. In reality, the cancer cell is not a powerful cell; it is a weak cell. It does not invade; it pushes out of the way- and it is not capable of attacking. Cancer cells are big, but they are sluggish and confused(Capra,1988:174).

Simonton states that once feelings of hope and optimism have been generated in the patient the "organism translates them into biological processes that begin to restore balance and to revitalize the immune system, using the same pathways that were used in the development of illness"(Capra,1988:175). Thus, the production of cancer cells diminishes while simultaneously the immune

system strengthens and becomes more effective in dealing these cells.

Simonton and his wife found that patients "who follow instructions implicitly and are enthusiastic about getting better, show marked relief of symptoms and dramatic improvement of their condition" (Samuels,1975:227).

In their early days of using visual imagery in the treatment of cancer patients, the Simontons discovered that the content of imagery was as crucial to positive outcomes as was its regular practice. They stated that "those individuals with negative imagery in which the cancer appeared more powerful than the treatment or the response of their bodies often did not do well"(Lerner,1994:165). The following account illustrates this notion. One of the Simontons' patients who although he steadfastly insisted that he was doing his visualization techniques three times a day was in fact, becoming sicker. When questioned about the content of his imagery, he revealed that he visualized his cancer as a big black rat, his chemotherapy as little yellow pills, and his white blood cells as white eggs in an incubator which one day would hatch. He told the Simontons:

I see the little yellow pills going into my bloodstream and once in a while the rat eats one of these pills....The rat is sick for a while, but he always gets better, and then he bites me all the harder(Simonton,1978:140).

According to the Simontons, this man's imagery paralleled his deteriorating condition. The cancer was symbolized as strong and powerful, the treatment weak and ineffective- tiny pills that the rat ate periodically, with only a temporary effect. Continuing, the Simontons stated:

(and) finally, the white blood cells, the representatives of the body's natural defenses , were completely immobile. Our patient had created an almost perfect image of total suppression of the immune system and had been faithfully repeating this imagery three times a day(Simontons,1978:140-141).

As a result of this observation, the Simontons' developed criteria for effective imagery: Cancer cells must be symbolize as weak and confused. Therefore they must be seen as something soft that may easily be broken down, like hamburger meat or fish eggs. They should not be symbolized as something strong and tenacious, such as the crab. The Simontons(1978:143) stated that

crabs, the traditional symbol for cancer, and other crustaceans are negative symbols. These beasts are tenacious, they hang on. They also have hard shells, making them relatively impregnable, and most people are afraid of them- the crab symbolizes the potency and the

fear of the disease.

The treatment must be symbolized as strong and powerful; healthy cells must be viewed as masterful in repairing any slight damage caused by the treatment. Finally, imagery of the white blood cells which are numerous and at most times effective in defending our bodies against disease should reflect their great numbers and strength (Pelton and Overholser, 1994:234).

In outlining their criteria for cancer imagery, the Simontons emphasized that they are suggesting *qualities* of the symbol not *what* the symbol should be. They (1978:154) maintained that

interpreting mental imagery is similar to interpreting dreams: It involves a highly personal, symbolic language. To translate the beliefs inherent in an image, then, you must 'try on' the image internally, identifying the meaning of its characteristic for you. The emotional meaning of a particular symbol may vary greatly for different individuals, so that a symbol that means strength and power to you may mean anger and hostility to someone else.

Consequently, the Simontons advised their patients not to accept, automatically, the imagery of someone else. They emphasized that whatever the symbol, its importance lies in the meaning it evokes for the patient, a meaning which, it is up to the patient to recognize (Simontons, 1978:154).

In his latest book *Healing Journeys* (co-authored not with his ex-wife but with a former patient) Simonton outlines his five and a half day program for cancer patients which includes a series of guided "meditations". These meditations range from creating appropriate images for the treatment of cancer, to communicating with your 'inner wisdom'. In his latest book, Simonton does not address directly, the issue of the effectiveness of multi-sensory imagery versus visualizations. Yet, in the meditation on "communicating with your inner wisdom" he advises his readers that if they have difficulty in visualizing an inner guide, they should "let the inner wisdom manifest in a thought or voice or feeling" (Simonton and Hanson, 1992:89).

Imagery therapist Achterberg also treats cancer patients. In her use of visual imagery for cancer patients, she follows a specific protocol. Firstly, she carefully analyses her patient's imagery so that she comes to understand the beliefs and knowledge which the patient has of the disease and its treatment. She does this by asking the patient to draw imagery of the disease, its treatment and the body's defenses. She (1985:105) states that at this point,

the therapist's goal...is to create a canvas upon which the intimate knowledge of the disease can then be drawn, but not to program or suggest images. It is upon the initial hunches, the emotions, the strength given to the disease and the defenses rallied against it that therapy is based.

Then she evaluates these three major components in terms of the imagery's vividness and effectiveness. For instance, the treatment imagery is examined for its vividness and its effectiveness as a mechanism for cure(Achterberg,1985:105).

As a result of this evaluation, Achterberg learns how well the person is coping with the disease, whether or not the images are consistent with medical facts and "who's winning- the disease, treatment or host defenses"(Achterberg,1985:105). Often, her analysis of the disease reveals meanings which are unconscious to the patient and reflects underlying negative attitudes or feelings about the disease. She insists that this issue needs to be addressed if imagery is to be therapeutic. For example, one of her patients revealed through her drawings of her cancer imagery that, at an unconscious level, she was feeling hopeless about her condition. She portrayed her cancer as logs in a log jam, with one single man representing a single white blood cell. The notion that white blood cells are a vast army of power, strength, and cunning, who are utterly capable of ridding the body of the cancerous cells was absent in her imagery, thus reflecting her feelings of hopelessness(Simontons,1978:154-155).

For Achterberg the exploration of diagnostic imagery serves as a basis for the use of visualization as therapy. Following her assessment of the patient's imagery, Achterberg suggests how the patient might alter it so that it will be more effective. She makes certain that the patient's imagery conforms to the disease process(Achterberg,1985:106-7).

Achterberg(1985:107) maintains that in their visualizations,

most people experience definite sensations in whatever are they are concentrating on. They 'try on' images until they find ones that fit, and they describe spontaneous changes in images, which often foretell important physical changes.

"John", a patient of the Simontons' illustrates this phenomenon well. "John" had developed strong symbolic imagery for his white blood cells, visualizing them as a vast army of white knights with sharp lances who

charged through the landscape on horseback, killing the cancer cells which were visualized as puny and lethargic. Prior to one of his reoccurrences in his cancer, his imagery changed: the lances became limp and rubbery and his horses transformed into ungainly dogs. In the Simontons' view, this alteration in cancer imagery foreshadowed a physiological change in his body: the resumption of his cancer (Simontons, 1978:142). I suggest that John's experience illustrates Gendlin's notion that bodily knowledge may be expressed through imagery; it also exemplifies Achterberg's view that physiological correlates of the image may precede physiological changes.

On a more positive note, Achterberg describes the experiences of those who make unexpected recoveries. These individuals may feel extreme heat, tingling, numbness or itching in the area of the disease- all compatible with an enhanced immune response. She (1985:103) states that

sometimes the first clue that disease is going away comes in a dream or in a state of reverie. The treatment is often said to lead to a sense of calm and diffused warmth and comfort as the disease is released. People describe images of being filled with white light, or of seeing an incandescent globe hover over their bodies right before they have the sense of being healed.

Brigham, also offers cancer patients a treatment program which includes imagery. Imagery is set within the context of her twenty eight day outpatient program which is based on psychoneuroimmunological (PNI) principles and expressed in a behavioural medicine program (Brigham, 1994:37).

In her treatment of cancer she re-iterates the guidelines set out by the Simontons: namely, that the "disease symbol should be seen as weak, less intelligent, non-menacing or non dangerous, smaller, less active, and less defined than the image of the healing process"; "the healing symbol needs to be seen as powerful, intelligent, active, vivid, focused, competent, and large", and the treatment should be "visualized as eminently effective- with healthy cells protected from the radiation or chemotherapy designed to destroy the unhealthy cells" (Brigham, 1994:140).

Like the Simontons and Achterberg, Brigham does not prescribe specific imagery for cancer. Rather she suggests what she terms *seeds* for imagery which incorporate these criteria. For example, she (1994:338) suggests that the cancer patient may choose to see the immune system as powerful, giant eagles

feeding on kernels of corn (cancer cells) or the cancer may also be symbolized as food for the healthy cells in the body. She reminds us again that the imagery chosen must reflect deep personal meaning and metaphor in order that it effect beneficial biological changes.

Naparstek has developed a guided imagery for the cellular level of the body which she asserts serves as appropriate imagery for cancer. Congruent with her belief that the imagery experience must be multisensorial and should incorporate kinesthetic dimensions, the patient is asked during the imagery procedure to place his or her hands on the area of the body under which the glands containing the immune cells are found(Naparstek,1994:95).

Having discussed some of the criteria and guidelines for imagery in the treatment of cancer, I now explore the principles and practices of imagery in the treatment of arthritis.

Visualizations in the Treatment of Arthritis.

Imagery such as visualizations is used in the treatment of arthritis. However, in advocating its use one must be aware of the different types of arthritis and the implications of these differences have on the content of the imagery used. Arthritis has many forms. One of its major divisions is that of inflammatory versus non- inflammatory categories. Under the inflammatory division, one finds autoimmune diseases such as rheumatoid arthritis. An autoimmune disease is one in which the body's defense system, the immune system, mistakenly recognizes part of itself as foreign and attacks itself. As Naparstek(1994:211) states: "Overactive or misdirected immune cells attack the body's own tissues". Symptoms which result may include joint swelling, swelling of the soft tissues around the joint, as well as bony erosions of the joint itself. In the non-inflammatory type of arthritis, such as osteoarthritis, joint changes might include disruption of the joint cartilage and proliferation of new bone at the margins of the joint.

As a consequence of these different pathologies, Naparstek cautions that imagery content must differ. In the case of autoimmune diseases, she states that "corrective imagery should include among other things, 'filling in' the bone at the eaten-away places, to return it to a more normal shape and size; whereas in the case of osteoarthritis, the correct imagery would attempt to 'reduce' the excess buildup on the bone"(Naparstek,1994:60).

Brigham describes the qualities of effective imagery for autoimmune disease such as rheumatoid arthritis. She(1994:140) advises "that with autoimmune diseases the disease symbol may, in the beginning be seen as wild, burning, and raging - but eminently tamable reversible, or manageable". In choosing a potent healing symbol, Brigham(1994:140) suggests the patient use a symbol that "befriends and tames the immune system without vitiating its protective attributes". Similarly in instances where medication is used as treatment to suppress the immune system, treatment symbols should be seen as "quite selective- acting only on the elements that need suppression without creating negative effects in other functions of the body"(Brigham,1994:141).

In summary, in this chapter I have discussed the western culture's dominant model of health and disease with reference to its tenets, particularly its premise of mind-body dualism which is a focal point of challenge by developments within and outside this model. Also in this chapter, I have identified some of the practices which advocate change in this theoretical framework. In this context, I discussed certain phenomena within western culture which are challenging biomedicine's dualistic notion of mind and body, phenomena such psychoneuroimmunology, biofeedback, quantum physics and the alternative systems of medicine. In my discussion of the alternative systems of medicine I noted that, as well as attempting to mend the separation of mind and body, they are challenging biomedicine's reductionist approach to treatment, calling for a change to holistic views and practices.

In addition in this chapter, I have discussed the use of visual imagery, presenting its use in a broad cultural context before focusing on its clinical applications in physical diseases of cancer and arthritis. In my examination of the criteria and guidelines, I identified some of the changes which have taken place in its practice, specifically with respect to the types of imagery advocated. I noted too, the debate between imagery therapists concerning the effectiveness of symbolic versus anatomically correct imagery, as well as the effectiveness of aggressive versus gentle imagery.

In my examination of these changes which are occurring in western medicine, I have observed a recurring theme. It is a theme which suggests resistance and struggle. Such a theme, I suggest, is the context in which some of these changes are taking place. Particularly with regard to the alternative systems of medicine, in many instances the biomedical establishment is

resisting the changes which this 'unconventional' system is advocating. Traditionally minded biomedical practitioners are attempting to keep the lid on these practices through their power to control health practices via their licensing bodies. In addition, psychoneuroimmunology has struggled to be accepted as a legitimate field within biomedicine because of its challenge to biomedicine's notion of mind-body dualism, as well as its practice of reductionism. Furthermore, as a result of the power of the biomedical model and the scientific paradigm it represents, we are told that quantum physics has hardly permeated conventional biology or medicine. In the following chapter, I shall examine this theme of resistance and struggle within western culture's field of medicine through the lens of Pierre Bourdieu's theory of cultural change whose underlying premise is that cultural change occurs within this context of contestation and competition.

Chapter 3

A Theory of Cultural Change

In the introduction to this thesis, I gave an overview of Pierre Bourdieu's theory of cultural change and briefly outlined the reasons for my decision to choose this framework to explain the changes which I have observed in western culture's predominant model of health and disease: the biomedical model. In this chapter I conduct an intensive examination of this anthropologist's conceptual understanding of cultural change, while at the same time applying his theory to what is happening within this prevailing model. The essential question I attempt to answer is: how well does his theory explain what is happening to the medical beliefs and practices of western culture with regard to change? Does it help us to understand the new developments which have taken place within biomedicine? For example, does it help to explain the emergence of new practices, such as visualization therapy and biofeedback? Does this theory offer an explanation for the resistance by the medical establishment to the changes in biomedical beliefs and practice which are confronting them? These are some of the questions which I will explore through the lens of this anthropologist's theory.

Pierre Bourdieu's Theory of Culture Change: Field, Habitus and Capital

As mentioned in the introduction of my thesis, Bourdieu views culture as dynamic (Bourdieu and Wacquant, 1992:18). In his view, its dynamic quality rests on the notion that groups within society continuously struggle over desired symbolic or material commodities and the power these commodities confer on those groups who possess them. Bourdieu argues that groups within culture are either attempting to transform or preserve the status quo; thus, culture is not static (Bourdieu, 1992:16-18). In my examination of the biomedical model in which I attempt to identify some of the changes within it, I have detected elements of contestation and competition. I suggest that what is taking place is a struggle between practitioners of a three hundred year old model of health and disease which wishes to retain its practices, as well as the theoretical foundation upon which these practices are based, and those groups who advocate fundamental changes in its ideology and epistemology.

New developments in research and technology within biomedicine, new modalities of treatment such as biofeedback, visualization therapy, as well as an insistence by alternative systems of medicine to adopt their more holistic approach in their health practices, have created a demand that biomedicine shift its ground. I argue that the keepers of the biomedical tenets and practices, such as medical schools, medical licensing boards, the traditional medical establishment, in many instances, are resisting these changes. They are struggling to maintain biomedical tenets of mind-body dualism, as well as an epistemology of reductionism. In essence, these groups insist that they will continue to define the predominant model of health and disease in Western culture.

Bourdieu argues then, that cultural transformation, and for that matter its preservation, occurs within this context of contestation. In his effort to understand the mechanisms by which a culture either transforms or reproduces itself, he puts forth his concepts of *field*, *habitus* and *capital*. Underlying these concepts is his approach to understanding the nature of culture.

For Bourdieu, the goal of anthropology is "to uncover the most profoundly buried structures of the various social worlds which constitute the social universe, as well as the mechanisms which tend to ensure their reproduction or their transformation"(Bourdieu and Wacquant:1992:7). Rather than proposing a grand theory to explain the social world Bourdieu seeks a methodology to understand it. This methodology is based on two principles: firstly, that the focus of study in sociology/anthropology should be on relations amongst groups within society rather than on individuals and their interactions, and secondly, that societal social structures have a double reality. In discussing this first principle, Bourdieu states: "What exists in the social world are relations- not interactions between agents or intersubjective ties between individuals, but objective relations which exist independently of individual consciousness and will..."(Bourdieu and Wacquant, 1992:97). He concurs with Marx's statement that "society does not consist of individuals; it expresses the sum of connections and relationships in which individuals find themselves"(Bourdieu and Wacquant,1992:16). Even when Bourdieu considers the individual, he chooses the term 'social agent' in order to reinforce his idea of the individual as a socially constructed being.

In his second methodological principle Bourdieu argues that social structures have a double reality (Bourdieu and Wacquant, 1992:7-8). Therefore, to understand the social world, one must take a double reading. In the first reading of society one must take an objective stance and focus on it as an "objective structure, grasped from the outside, whose articulations can be materially observed, measured, and mapped out independently of the representations of those who live in it" (Bourdieu and Wacquant, 1992:7-8).

Yet, to fully understand the social world Bourdieu argues that one cannot focus solely on these objective relations but one must acknowledge also that "consciousness and interpretations of agents are an essential component of the full reality of the social world" (Bourdieu and Wacquant, 1992:9). Social reality is also a "contingent ongoing accomplishment of competent social actors who continually construct their social world via the organized artful practices of everyday life" (Bourdieu and Wacquant, 1992:9). Therefore, the sociologist/anthropologist must take a second reading of the social world in order to address its subjective aspect and the part it plays in the ongoing production or transformation of culture. As he states:

Through the lens of social phenomenology, society appears as the emergent product of the decisions, actions, and cognitions of conscious, alert individuals to whom the world is given as immediately familiar and meaningful. Its value lies in recognizing the part that mundane knowledge, subjective meaning, and practical competency play in the continual production of society; it gives pride of place to agency and the 'socially approved system of typifications and relevance' through which persons endow their 'life world' with sense (Bourdieu and Wacquant, 1992:9).

To elaborate on the nature of this double reality of culture and to understand its mechanisms of change, Bourdieu discusses three interrelated concepts: *field*, *habitus* and *capital*. In his earlier book *Outline of a Theory of Practice*, Bourdieu does not use the term field. Rather, he speaks of "structures constitutive of a particular type of environment which produce habitus" (Bourdieu, 1977:72). However, in his conversations with Wacquant in their book *An Invitation to Reflexive Sociology*, the concept of field is discussed (Bourdieu and Wacquant, 1992: 97)

In his conceptualization of *field*, Bourdieu is taking his first reading of the social world by looking at its objective aspect. In his concept of field, Bourdieu rejects the view that society consists of a "seamless totality integrated

by systemic functions... or an overarching authority"(Bourdieu and Wacquant,1992:16). Rather, he views society as an aggregation of relatively autonomous social spaces where social agents occupy different positions vis a vis power. He defines this concept as

a set of objective, historical relations between positions anchored in certain forms of power (or capital)....[It is] a network...of objective relations between positions.... These positions are objectively defined, in their existence and in the determinations they impose upon their occupants, agents or institutions, by their present and potential situation in the structure of the distribution of species of power (or capital) whose possession commands access to the specific profits that are at stake in the field, as well as by their objective relation to other positions (domination, subordination, homology, etc.)(Bourdieu and Wacquant,1992:16,97).

Each field determines its own values and possesses its particular rules and regulations. As such, "these principles delimit a socially structured space in which agents struggle, depending on the position they occupy in that space, either to change or to preserve its boundaries and form"(Bourdieu, and Wacquant, 1992:17).

Conceptualized in this way, a field is a space of struggle and competition as groups who occupy different positions in the field contest one another in order to preserve or to gain control over the particular species of capital which is dominant and operative in the field(Bourdieu and Wacquant, 1992:17). Because of this element of struggle for power, Bourdieu's concept of field is also a locus of change. Its structure may change; its boundaries, its form, its divisions may be altered through a modification of the capital within the field. Thus, a field is not a static entity but a dynamic one. Bourdieu states:

In the course of these struggles, the very shape and divisions of the field become a central stake, because to alter the distribution and relative weight of forms of capital is tantamount to modifying the structure of the field. This gives any field a historical dynamism and malleability that avoids the inflexible determinism of classical structuralism..... Any field.. presents itself as a structure of probabilities- of rewards, gains, profits, or sanctions-but always implies a measure of indeterminacy"(Bourdieu and Wacquant, 1992:18).

In his discussion of his second concept, that of *habitus*, Bourdieu takes his second reading of the social world. In his view, *habitus* illustrates the subjective aspect of the social world's dual nature, stating that "social reality exists, so to speak, twice, in things and in minds, in fields and in *habitus*,

outside and inside of agents"(Bourdieu and Wacquant, 1992: 127). Bourdieu describes habitus as the tendency of social agents to follow patterns of perception and behaviour to which they have been enculturated by the position they occupy in social structures. He defines it as a

set of historical relations 'deposited' within individual bodies in the form of mental and corporeal schemata of perception, appreciation and action....a system of lasting and transposable dispositions which, integrating past experiences, functions at every moment as a matrix of perceptions, appreciations and actions and makes possible the achievement of infinitely diversified tasks..... as a structuring mechanism that functions within the individual though it is neither strictly individual nor in itself does it fully predict behaviour or perception(Bourdieu and Wacquant, 1992: 16,126,18; Bourdieu,1977:82-83).

Furthermore, he argues that habitus and field are genetically linked, in that habitus is the bodily manifestation of the objective social world. As he states:

social divisions and mental schemata are genetically linked: the latter are nothing other than the embodiment of the former. Cumulative exposure to certain social conditions instills in individuals an ensemble of durable and transposable dispositions that internalize the necessities of the extant social environment, inscribing inside the organism the patterned inertia and constraints of external reality(Bourdieu and Wacquant,1992:13).

Not only is habitus the embodiment of the field as manifested in the perceptions and experiences of individuals but Bourdieu also argues that habitus and field condition each other: "The field structures the habitus and at the same time the habitus constitutes the field as a world endowed with meaning, sense and value"(Bourdieu and Wacquant, 1992:127). As he states: "When habitus encounters a social world of which it is the product, it is like a 'fish in water' (Bourdieu and Wacquant, 1992:127). As consequence of this internalization of external structures habitus responds to situations and events in the field in a roughly coherent and systematic way.

Yet, Bourdieu's habitus is also a locus of change. Although habitus favours agents to respond to a situation in a predictable and systematic way thereby encouraging the reproduction of culture, habitus does not *prohibit* change. As Bourdieu cautions, habitus is only a *tendency* towards feeling or acting in a certain way; it is not a *prescription* for certain behaviours or thinking. Habitus is constantly subjected to experiences and their effects

which may result in cultural transformation through a change in habitus(Bourdieu and Wacquant,1992:131-133). In response to a question from Wacquant that does not his theory of habitus and field allow no room for innovation and conscious deliberation or choice, Bourdieu responds to Wacquant's question by saying:

The immediate fit between habitus and field is only one modality of action, if the most prevalent one....llabitus is not the fate that some people read into it. Being the product of history, it is an open system of dispositions that is constantly subjected to experiences, and therefore constantly affected by them in a way that either reinforces or modifies its structure. It is durable but not eternal(Bourdieu and Wacquant,1992:131-133).

As well as conditioning each other Bourdieu maintains that habitus and field function fully only in relation to each other. A field is a space of play which exists as such only to the extent that players aspire to enter and work actively in the field in order to gain the resources, and consequently the power to mold the social world into the image which best suits their particular interest. Thus, Bourdieu asserts that

an adequate theory of field requires a theory of social agents: There is action and history and conservation or transformation of structures only because there are agents, but agents who are acting and efficacious only because they are not reduced to what is ordinarily put under the notion of individual and who, as socialized organisms, are endowed with an ensemble of dispositions which imply both the propensity and the ability to get into and to play the game(Bourdieu and Wacquant,1992:19).

In conclusion, Bourdieu argues at the proper object of social science is

the relation between two realizations of historical action, in bodies and in things. It is the double and obscure relation between habitus, that is, the durable and transposable system of schemata of perception, appreciation, and action that result from the institution of the social in the body, and fields, that is, systems of objective relations which are the product of the institution of the social in things or in mechanisms that have the quasi reality of physical objects; and, of course, of everything that is born of this relation, that is, social practices and representations, or fields as they present themselves in the form of realities perceived and appreciated(Bourdieu and Wacquant,1992:126-127).

Finally, in his discussion of the third fundamental concept of his conceptual framework, that of *capital*, one discovers that it also is a locus and

mechanism of cultural change. Bourdieu defines *capital* as that entity (may be symbolic) "which is efficacious in a given field, both as a weapon and as a stake of struggle, that which allows its possessors to wield a power, an influence, and thus, to exist, in the field under consideration, instead of being considered a negligible quantity" (Bourdieu and Wacquant, 1992:98-99).

Capital may exist in economic, cultural, social and symbolic form. Although there are forms of capital which are valid and efficacious in every field, each field holds its own values which in turn determines its species of capital. For example, in the artistic field its capital is cultural authority, whereas in the scientific field it is scientific authority.

Yet the value of a species of capital within a field does not remain constant; it may change. Using an analogy of a game in which social agents are the players and the field is the game, Bourdieu states that players may play to increase or conserve their capital depending on whether or not they wish to maintain the status quo within the field or whether they wish to change it. In the latter case, players work to change the relative value of the different species of capital by discrediting the form of capital upon which the force of their opponents rests (e.g. economic capital) and by enhancing the value of the species of capital they preferentially possess (e.g. juridical capital) (Bourdieu and Wacquant, 1992:99).

In his discussion of capital, Bourdieu emphasizes that it exists and functions only in relation to a field. It must be something that the field values and where its competency can be deployed. Its deployment "confers power over the field, over the materialized or embodied instruments of production or reproduction whose distribution constitutes the very structure of the field, and over the regularities, and the rules which define the ordinary functioning of the field, and thereby over the profits engendered in it" (Bourdieu and Wacquant, 1992:101).

Having explored Bourdieu's understanding of the mechanism of reproduction or transformation of culture through an examination of his concepts of field, habitus, and capital, I now relate these concepts to the challenges biomedicine faces and to the changes which I proposed have taken place in its tenets and practices. Using these concepts I analyse the challenge which the biomedical model faces from phenomenon such as the alternative systems of medicine. Firstly, I discuss the biomedical model and the alternative

systems of medicine in terms of Bourdieu's concepts of field and capital. Then, I focus on Bourdieu's conceptualization of habitus to explain the changes which I propose have occurred within biomedical views and practices.

Analysis of Biomedicine from Pierre Bourdieu's Theory of Cultural Change.

Bourdieu describes society as an aggregation of relatively autonomous social spaces in which social agents occupy different positions vis-à-vis power. From this perspective, I suggest that the biomedical model of health and disease and the alternative systems of medicine, form a social space in which each occupies a different position in terms of power. In this instance, biomedicine, not the alternative systems, is dominant and as such biomedicine controls the levers of power which allow it to define the medical ideologies and practices which are deemed to be legitimate.

Biomedicine may be objectively defined through its external social structures such as medical associations, research bodies, medical schools, licensing boards, hospitals, pharmaceutical companies, and the medical establishment. These bodies may "materially observed, measured, and mapped out, independently of the representations of those who live in it" (Bourdieu and Wacquant, 1992:8). Therefore I argue that biomedicine exemplifies Bourdieu's concept of field which Bourdieu proposes is the objective dimension of the dual nature of society.

As previously mentioned, biomedicine is the dominant medical model in the Western world. Anchored in economic and symbolic capital, it attempts to control the scope and tenets upon which medical practices are based. It sets medical curriculum in medical schools; it lays charges against those physicians who stray outside its tenets and epistemology. It discredits other forms of medical theories and practices, labelling them as quackery and fraudulent. As well, it controls the allocation of public funding for research. These actions, I suggest illustrate Bourdieu's concept of capital.

In his discussion of capital Bourdieu defines it as "an entity which is efficacious in a given field, both as a weapon and as a stake of struggle, that allows its possessors to wield a power, an influence, and thus, to exist in the field under consideration, instead of being considered a negligible quantity" (Bourdieu and Wacquant, 1992:98-99). In its above actions of restraint

and constraint, biomedicine, I suggest, uses its control over capital both as a weapon, and as a means to exist in the field as the most powerful player. As the most powerful player, it determines the legitimate medical beliefs and practices of the Western world.

The question arises: what does biomedicine consider to be capital? As Bourdieu has proposed, each field has its own values which determine its species of capital. I suggest that biomedicine esteems and possesses several forms. One: it possesses economic capital which gives it the resources to maintain its dominant position in the medical field. Two: it esteems and possesses scientific authority which is part of the world view of western culture as the determinant of what is considered to be valid knowledge. Three: Linked to this notion of scientific authority, it commands a prestige and esteem from public, giving it a credibility in its eyes as the prime authority of legitimate health practices. Yet, Bourdieu ascribes another quality to his concept of field.

Bourdieu also sees *field* as a forum of struggle and competition as groups who occupy these different positions in terms of power, contest with one another either to maintain this power or to gain control over the particular species of capital which is dominant and operative in the field. In this context then, although the biomedical model is the dominant model of the western world, its position does not remain unchallenged. Rather these alternative systems of medicine contest biomedicine's claim to define, exclusively the prevailing model of health and disease of Western culture.

These alternative systems of medicine, as I have discussed earlier in my thesis, encompass a wide range of ideologies and practices. Like biomedicine, I suggest that they may be considered as a 'field', although they are not as institutionalized as biomedicine because of their subdominant position. Still, they have their external social structures which can be determined objectively in the social world: Chiropractic practitioners and acupuncturists have their schools; homeopathists run clinics, and alternative health practitioners open practices.

Although these medical systems may encompass diverse medical ideologies and practices, I suggest that they are united in two aspects: they challenge the tenets and epistemology of biomedicine and they demand to be included as a legitimate part of the West's system of medicine.

In these challenges and in this demand, I suggest that the alternative systems of medicine illustrate two aspects of Bourdieu's notion of capital: its conceptualization as a stake in the struggle for power and its changing nature. Bourdieu has stated that players, in their struggle to transform the field may work to change the relative value of the different species of capital by discrediting the form of capital upon which the force of their opponents rests, and by enhancing the value of the species of capital they preferentially possess. I suggest the alternative systems of medicine are attempting to diminish the importance of the scientific basis in assessing the validity of medical practices, which is one of the forms of capital which biomedicine possesses. At the same time, they are attempting to enhance the value of what I suggest is one of their species of capital: the holistic approach in the treatment of patients.

In Bourdieu's consideration of capital as a stake of struggle in the field, I suggest that the esteem and patronage of the public express this aspect. It is within this context that the alternative systems of medicine struggle with biomedicine for the esteem and patronage of the public which biomedicine, presently because of its dominance in the field, is able to use as a weapon.

In their struggle for power, I suggest that these alternative systems are also trying to alter the boundaries and form of the field. They are attempting to enlarge its boundaries, as well as its form, by demanding the inclusion of their medical practices within a modified biomedical model. They are attempting to make these changes to the field by altering the form of capital in the field. Specifically they are trying to diminish the value of scientific epistemology and enhance the value of their own epistemology: that of holistic approach to medical treatment. In this instance the field itself, as Bourdieu has argued, becomes a central stake in the struggle: "In the course of these struggles the very shape and divisions of the field become a central stake, because to alter the distribution and relative weight or form of capital is tantamount to modifying the structure of the field" (Bourdieu and Wacquant, 1992:127). Indeed, if the weight of public esteem and patronage, through the struggles of these presently unconventional therapies and practices shifts to its side, thus, pressuring biomedicine to include these alternative medical practices and approaches to treatment, then indeed, the field of Western medicine would alter, both in boundary and form. Such modifications would illustrate as well,

the dynamic quality of field which Bourdieu attributes to this concept.

Moreover, the fact that these non- biomedical systems of medicine wish to engage in this struggle for power illustrates a further argument of Bourdieu's: his notion that habitus and field function fully in relation to each other, that a field exists only to the extent that social agents wish to engage in the field in order to mold the social world to their liking.

In summary, I have examined the relationship between biomedicine and the alternative systems of medicine from Bourdieu's concepts of field and capital, showing them as two fields engaged in a struggle over the power to determine the dominant model of health and disease in Western culture. While biomedicine struggles to preserve the status quo, the alternative system of medicine works to change it. Yet, in the previous chapter I showed that changes that have already taken place in biomedical practices. The emergence of the field of psychoneuroimmunology, the development of practices of biofeedback, the practices of visualization therapy are examples of changes within the biomedical views and practices. The increased use of chiropractic and acupuncture treatment in biomedical practices, the establishment of an office for the study of Alternative medicine within the National Institute of Health which is the United State's leading public institution for medical research are other examples. How does Bourdieu's theory of cultural change explain these changes? Their explanation, I suggest, lies within Bourdieu's concept of *habitus*, a concept which acknowledges the subjective nature of the social universe.

In his discussion of habitus, Bourdieu has defined it as the tendency for social agents to follow patterns of perception and behaviour, to hold beliefs and tenets to which they have been enculturated by the position they occupy in social structures (Bourdieu and Wacquant, 1993:130). *Field* structures habitus so that habitus constitutes the field as a world endowed with meaning, sense and value.- like a 'fish in water' (Bourdieu and Wacquant, 1993:127). Seen in this context, I suggest that habitus provides an explanation as to why the medical establishment supports the fundamental premises and practices of the biomedical model. Upon entrance to medical school and gradually, through its biomedical curriculum, physicians are enculturated into its tenets and epistemology. As a result, they experience these beliefs and practices as right and natural 'like a fish in water' and they view other medical beliefs and

practices which counter these views as invalid and mistaken. Yet, if field structures habitus in this manner, how does one explain cultural change? What moves physicians, enculturated in the biomedical model, to change their views, and indeed their medical practices? In this instance we must look at the second dimension of Bourdieu's concept of habitus: habitus is a *tendency* rather than a *prescription* to follow patterns of thinking and behaving, as enculturated by one's position in social structures. As Bourdieu has stated:

Habitus is not the fate that some people read into it. Being the product of history, it is an open system of dispositions that is constantly subjected to experiences, and therefore constantly affected by them in a way that either reinforces or modifies its structure. It is durable but not eternal (Bourdieu and Wacquant, 1992:131-133).

Thus, habitus can be altered by the subjective experiences of alert, reflective individuals as they go about their daily routines. Bourdieu has asserted that "the social reality is also a contingent ongoing accomplishment of competent social actors who continually construct their social world via the organized artful practices of everyday life" (Bourdieu and Wacquant, 1992:9). Observant, reflective individuals while carrying out their daily routines may have insights which fundamentally alter their beliefs and practices. Psychoneuroimmunologist Felten exemplifies this instance. Through his observations and in his interactions with his patients he felt that social support and positive emotions likely enhanced the body's immune system. As a result of this observation he challenged his colleagues to stop focusing solely on variables which suppressed the immune system and to start looking at the positive variables, ones which might effect beneficial health outcomes.

Naparstek and Brigham modified their beliefs and practices of imagery as a result of observing their patients. As a consequence of these observations, they moved beyond the sole use of visualizations to include other sensory modes such as auditory and kinesthetic senses. These changes in habitus came about through these "organized artful practices of everyday life" of which Bourdieu speaks.

Bourdieu's notion that habitus may be modified by subjective experiences and that as a result of such experiences, social change may occur, is illustrated, I suggest, in the development of the discipline of psychoneuroimmunology within biomedicine, as well as in the emergence of biofeedback in biomedical practices. Observed links between the central

nervous system and the immune system which were discovered through the practices of medical research led to change in medical habitus which posited that indeed, there are links between the central nervous system and the immune system. This change in medical habitus led to the development of the new discipline of psychoneuroimmunology.

As a result of his research, Neal Miller changed his belief, and those of other biomedical practitioners that the autonomic nervous system was beyond conscious control. As a result the *field* of biomedicine expanded its boundaries to include biofeedback techniques. Within this function of habitus, lies Bourdieu's argument against the inflexible determinism of classic structuralism.

In this chapter, I have discussed the conceptual framework of Pierre Bourdieu, presenting his concepts of field, habitus and capital through which he proposes to understand the reproduction and transformation of culture. Then, I applied his theory to the changes which I identified as having taken place in western medical beliefs and practices. In my analysis, I attempted to answer the questions which I posed at the outset of this chapter such as how effective is Bourdieu's theory in understanding the changes which are occurring in biomedicine? Does it help us to understand the new developments which have taken place? Does it help to explain the emergence within biomedical practices of modalities such as visualization therapy and biofeedback? In my view, Bourdieu's concept of habitus provides an excellent explanation of these changes. As he states "habitus is a structuring mechanism that is operative from within agents, though it is neither strictly individual nor in *itself fully determinative of conduct*" (Bourdieu and Wacquant, 1992:18). It is this latter aspect of habitus which is the locus of change. Although habitus is an embodiment of the field, and is conditioned by it to hold certain beliefs and behaviours, it may be influenced and changed by subjective experiences of contemplative, alert individuals during their daily activities. New ways of thinking, novel perspectives, and behavioural changes may happen as a result of these subjective experiences. I suggest that it is this aspect of habitus which explains how the discipline of psychoneuroimmunology emerged within biomedicine, as well as how modalities of biofeedback and visualizations began to be practiced.

In this chapter I also posed the question, does Bourdieu's theory offer

an explanation for the resistance of the medical establishment to changes in medical practices called for by the alternative systems of medicine? I suggested that it is Bourdieu's concept of habitus which explains its resistance to change. In this instance, I proposed that it is the structuring aspect of habitus which perpetuates certain beliefs, attitudes and behaviours. I suggested that it is the medical curriculum which enculturates physicians to adopt the tenets of biomedicine: its notion of the biological basis of disease, separation of mind and body and reductionist approach to treatment. As a result of this structuring function of habitus, other approaches are experienced as invalid and unworthy of attention, if in fact they are considered at all. A statement by Cunningham illustrates this function of habitus. In response to the question why hasn't the possibility of the mind as having an impact on cancer (and other diseases) influenced medical practices, Cunningham(1992:67) responded: " To many of those trained exclusively in biology or medicine, mind seems intangible and unable to affect the concrete processes of the body".

In the following chapter, I present my fieldwork in which I examine the beliefs and practices of those health practitioners, some of whom who have incorporated the 'intangible' mind into the care and treatment of their patients.

Chapter 4

Fieldwork: What Quackery is This!

In my view, the purpose of fieldwork is to try and come to some understanding of how people in a community or culture understand a particular phenomenon. With this goal in mind, then, I attempted in my fieldwork to gain some sense of how those in the health field, either as caregivers or as patients, understand the phenomenon of visualizations. Using a semi-structured format, I talked with two physiotherapists who use visualizations in their practice. I conversed with a social worker, a nurse and a counsellor who use visualizations with their cancer or arthritis patients. I discussed the use of visualizations with an oncologist in an attempt to understand his conceptualization of this process. Last, but certainly not least, I explored the meaning and practice of visualizations from the perspective of a person with cancer. In order to maintain the confidentiality of my informants, I changed their names.

As I discussed in the introduction to my thesis, I decided to adhere to a reflexive epistemology which argues that the researcher is an inherent part of the research process, affecting the data which her or she obtains. Therefore, I argue that my feelings, my gender, my age, my interpersonal and interview skills affect the information I obtain (or do not obtain!) during the interview. I concur with Hammersley and Atkinson(1991:165) who have said:

In the first place our feelings enter into and colour the social relationships we engage in during fieldwork. Secondly, such personal and subjective responses will inevitably influence one's choice of what may be noteworthy....problematic.... and what appears to be mundane or obvious. One often relies implicitly on such feelings, and their existence and possible influence must be acknowledged and, if possible, explicated in written form.

As I conducted my research I kept these issues in the forefront of my mind, and I endeavoured, as Hammersley and Atkinson suggest, to put them in written form where possible. When I did so, I used the italicized style of writing.

Again, as I mentioned earlier in my thesis, the implications of doing fieldwork in one's own culture can be problematic, according to Burgess who asks the question:

Does familiarity with one's culture breed, not contempt but rather a kind of blindness? Will researchers recognize patterns in a society in which they are thoroughly acculturated?...Will researchers give full coverage to situations with which they are already familiar(Burgess,1984:22)?

I concur with Burgess's view on this matter that in the interview settings I may be blinded to events which might in another setting catch my attention. Attempting to be mindful of these situations, I began my fieldwork.

Both nervous and excited, for this was to be my first fieldwork experience, I set off from my home to do my first interview. Prior to my leaving home, I had pressed, poked and played with the tape recorder, beseeching all the Buddha's to make sure it did its job well. I was going to interview Rosy Sperling, a nurse who did visualizations, mostly with psychiatric patients but who at times, also worked with cancer patients. We had not met before. We were to meet in the psychiatric department of the Ottawa General Hospital at 9:00 a.m.. An appropriate place, I thought to myself! As I sat in the small waiting room, eyeing the clock on the wall, my nervousness began to override my excitement. What if my tape recorder didn't work? What if I forgot all my questions? What if she was nasty, terse, and had agreed to this interview only because of an obligation to my friend Denise who had arranged this interview? Moments later, Rosy walked in the room, smiling warmly. Soon, with the tape recorder perched between us we began to talk...

Roswitha Sperling, Nurse and Transformational Fantasy therapist

Rosy Sperling works as a nurse in the psychiatric outpatient clinic at the Ottawa General Hospital. In conjunction with her nursing duties, she also conducts visualization sessions with these patients, using a technique called transformational fantasy. She learned this technique, approximately eight years ago, in a three week workshop given by its founder John Thomas Shaffer, after he had been invited by the psychology department of the Ottawa General Hospital to come and teach his technique to health care professionals such as Rosy.

Although for the most part she works with psychiatric patients, with illnesses such as depressions and borderline personality disorders, Rosy does, on occasion, conduct transformational fantasy sessions for people who have cancer. Mostly, she works one on one with her patients, usually on Fridays. Most often she conducts three sessions with each patient. Her role as a guide

is to follow closely and attentively, the patient's symbols, to ask questions about what's happening and to make the person aware of possible options of action in this personal inner drama. Yet, Rosy emphasizes that it is the patient who creates the imagery during this process.

According to Rosy, transformational fantasy

is a method in which you are.. put into a dream like state. You are working with your inner symbols and because of that, in a few sessions the patient will feel better. It is a very powerful way of helping oneself to get better.

In describing her work with cancer patients she states that

you completely rely on the message of the patient, of their ability to work.. You don't mention the word cancer...It doesn't matter what they have. You have certain staging areas (*within the body: right brain, left brain, center, body*) Usually you start by the centre.

In a session with a patient, Rosy might instruct him or her to

"Go inside of yourself. Its a visit which you do inside yourself and let's work. Your own living being will guide you on its own."

Conjuring up an imaginary patient Rosy says:

Close your eyes. Suddenly you (the patient) see two eggs coming. Don't they look lovely! Patient says "I hate eggs." You do?, responds Rosy. So what can we do with these eggs because you really don't like them. So the patient would ask for help with these eggs, to put them somewhere safe or to transform them. Then, you might ask the right brain, the left brain if there is anything which can help you so that these eggs can find a place where they are safe, to make your centre lighter, easier to work with.... We treat all our discoveries with reverence. So this is how it works. If you are a cancer patient eventually you will address all the staging areas of your body and suddenly you will say all the eggs are gone. But my goodness I'm outside. You feel ground under your feet. I say, 'Where are you?' Patient says 'In my garden....I think I'm in my stomach and isn't it lovely here.'

Rosy informs me that these imagery sessions are not a guided session, that she has to go where the person is, even though she might try to keep them focused in certain areas. When I asked her if she attempts to interpret the patient's symbols, Rosy emphatically said:

No! Never! Because the interpretation, it interprets itself... I could ask them, sit and analyze. If somebody asks me a question, I would answer with maybe one or two sentences but I would say let the symbols work for you and with you because once they have been met, they work in

their own wisdom. They educate the conscious mind in their own wisdom.

Furthermore, she continues:

I will tell you something. This is the good thing about it. Some people are easily frightened, angry people. The body will never, ever reveal anything which it isn't able to help. Never! So if you do this technique, the symbols will come up. But in their own wisdom they know that they are ready. The living being knows that and this is where this is so miraculous! We're so miraculously made!

Rosy strongly believes that this technique can help to make people better both physically and emotionally. She gives her reasons, stating:

If you have faith in, let's say your guide, if you have faith in yourself, whatever strength you have in you will help make you whole again, will make you better. This is what it is. They are working with their inner symbols... and because of that in a few sessions the patient will definitely feel better. It's a very powerful way of helping oneself to get better....Once we do an image together you feel different. There are certain things you never forget. Once you have them they follow you, but if you create harmony within yourself, you will create harmonies in the next circle of people you affect. That's how it works and by doing that you create harmony with the earth, and with yourself. You feel a togetherness. We all live in symbiosis with the trees, the earth.

When I asked Rosy, how she felt that images worked to make someone better, she handed me a book called *Holistic Nursing* which contained a chapter *The Psychophysiology of Bodymind healing*. And yes, she said

you can see better described from here what is happening in the brain during imagery, physiologically what is happening and from what we know where the memory centers are and how they conduct and send down into the body and how they communicate, how each cell is. Oh! It's amazing!

In my discussion with Rosy about the use of transformational fantasy, I inquired about the reaction of other health professionals. Did psychiatrists welcome this technique? Did she encounter resistance to it? 'Never!' was her response, although she thought that her 27 years as a nurse with a "lovely record in nursing and well respected" might account for their acceptance of her work in this type of visual imagery. Although no referral is necessary most of Rosy's clients are referred by psychiatrists, and family physicians. Her restraints are time and energy.

Thirsty and irritable, I pulled up to my friend Kim's house. How I

wished I had stopped off at home for a cup of tea! Reminding myself of Hammerseley and Atkinson's remarks of how feelings colour our social relationships, I wondered about the quality of this interview! Opening her bright pink door in response to my knock, Kim smiled a greeting. Almost immediately she asked me if I would like a cup of tea....

Kim Osprey, a cancer patient

Kim, a person who has had breast cancer but it is in remission, related her experiences with visualizations to me. Prior to her visits to her oncologist during which time she is assessed for a resumption of her cancer, Kim uses visual imagery. She states:

I use it to check out my body. Its a very effective tool for being relaxed, especially a few days before you go to the oncology clinic because that usually is a sensitive time. I generally put myself in a really relaxed state and then I go through my body very carefully and see if I feel myself if anything is wrong and usually what will show up is some kind of chronic ache or pain. It may not be cancer but it is uncomfortable. Its a check up where you are.

When asked to describe her visualization process she continued:

First of all, you have to relax, then for me its like a fine fine sieve and I know its got a gold edge on it. It starts at my feet and I just run it very carefully through my body very slowly. I visualize it travelling. It takes a long time to get from the bottom of my body to the top of my body and often I think when it gets to the top sometimes there is a little 'grunge' in there, black flakes and I think OK! I usually do it three times and then I get whatever is not healthful for me out. Then I go through my body very carefully and just check. Its like an x-ray.

Then, Kim states that she imagines herself standing in a stream whose banks are lined with irises which she says are the symbol for women. There, she immerses her sieve in the stream and the water carries the sediment, the black grunge away.

From Kim's perspective, her visualization process helps to reduce her anxiety and tension as she prepares herself for a return visit to the clinic. It also helps to give her some kind of control as she walks through the clinic doors. "Although you are an intelligent human being and you've made notes and done good things, what happens to you when you walk through that door, forget it, your brain just...!"

In conjunction with her visualizations, Kim also told me that she uses

music to relax. She may even use music in lieu of visualizations, particularly when she is unable to focus her mind on her imagery. She allows that although people with cancer are encouraged to use imagery daily, two or three times a day, especially when they are in active treatment, she herself does not use it daily now. Rather when she is feeling tense or something is bothering her and she can't get at it, she says that she puts on music she really enjoys.

Then I get comfortable and I concentrate on every aspect of the music. I concentrate on the notes. Its a form of meditation. It stops your mind from doing the spinning. If I start to do some active relaxation and then start to visualize, I find I just can't get rid of some thoughts.

During my interview I asked Kim if imagery was considered an integral part of cancer treatment. "No, she allowed, it's optional; it's up to the individual patient to decide." Patients have the option of attending support groups where relaxation and imagery is taught. Imagery is viewed as a way of minimizing or eliminating the side effects of treatment, say for example, that of chemotherapy. Also, Kim suggested that visualizations are used to enhance the treatment. In chemotherapy in which a red liquid is fed intravenously to the patient, often the patient begins to shake because the drug is cooler than the body. In the visualization process, the patients imagines that the shaking encourages this liquid to reach every part of his or her body, making the treatment more effective.

When I asked how oncologists viewed imagery, Kim felt that there was no one monolithic view.

I think there is as much variety among the medical community as from someone walking down the street. There are certainly lots of physicians.... At least my oncologist is quite open to it.

She stated that "the story I've heard is that most physicians will encourage you to do anything that will increase your sense of well-being, if it improves your quality of life." However, when asked whether her oncologist felt that imagery had a curative effect, Kim she stated that she did not know.

During our conversation, Kim discussed an implication of the notion that the mind has an effect on health, an implication which she finds "scary". She states:

There are a lot of patients who only think negatively and they think if even one negative thought crosses their mind, they are going to jeopardize themselves. When a person gets a life threatening illness,

the first thing they think is 'what did I do wrong'? We have this perception that we are in control but if someone gets a life threatening illness you are out of control. Its because in our culture we are so individualized and in control. Its also a neat way for the community to say 'oh, you must have done something wrong!' I lived in Asia for awhile, and in their culture, the whole community comes to the support of that person because they know that it could strike them just as much as anyone, they don't see them as a bad person, a failure.

Rosemary has been my good friend and colleague for twenty years. In addition, for the past eight years she has also been my neighbour. So when Rosemary knocked on my door in response to my invitation to be interviewed about her experiences with visualizations , I considered the impact of friendship and familiarity on the interview process. Trying to pin down the source of unfamiliar feelings of awkwardness and discomfort as I greeted Rosemary,(while at the same time, wondering how anyone could think that one could eliminate feelings from a social interaction!),I remembered Bernard's differentiation between the casual conversation of friends and the interview situation. He noted that in casual conversations people take more or less balanced turns and there is no feeling,that the conversation must stay on track or follow some theme, as there is in interview(Bernard,1988:207). And so, my awkward feelings arose from my concern that Rosemary and I might get sidetracked into casual conversation,and questions would remain unasked. I needn't have worried. Bright and articulate, Rosemary had done her homework. She led me through the interview!

Physiotherapist Rosemary Kinch

Rosemary Kinch, a physiotherapist began using imagery in its auditory aspect in 1957, when, as a student, she was asked to design programs for children with asthma, torticollis, and scoliosis. She relates:

I designed exercises for them where they would listen for the birdie or listen for the worms in the ground....That's when I first realized that by giving someone a picture, even at two and a half or three years old, you could get the result you wanted....To obtain a specific result as in a stretch : the opposite side in torticollis, its the opposite ear you put to the ground, listening for the worm. Then there is looking up for the birds....

When she began to work for the Arthritis Society in 1974 she

continued, albeit quietly, to use imagery, mostly in the form of visualizations. According to Rosemary visualizations have several roles to play in the treatment of arthritis. Certainly, visualizations, she maintains, are used to minimize pain. As she points out by visualizing doing something pleasurable, fun while doing exercises it "gives them [the patient] a train of thought away from the pain." She gives an example in which a patient doing exercises for his hips is encouraged to think of the steps at his son's house. "When I am doing hip flexion exercises, when we talk about a specific staircase, maybe his son's place is a split level house and he can't visit his son because of the five stairs so let's think about those five stairs and let's get up them." In this context, visual imagery is also motivational. Indeed, Rosemary stresses that "one of the biggest things is the empowerment it gives to the patient." For instance, she states that "if a patient *feels* they are walking in the market when they are walking into the kitchen, then they feel they *can* walk in the market."

In addition, Rosemary argues that visualizations are used to achieve specific physical effects. For example, she tells patients to visualize themselves in a box as they are doing stretching exercises.

If you are doing stretches, and its very important to keep stretched, then I have them sitting on the side of the bed and imagining they are in a box and they push away the front walls and they push away a little further to stop them from falling out, they push away the side walls and they think about that box or they may just actually be holding the walls of the room, they think about the walls of the room coming in, back off to see if they will stay, no, they won't stay so they give them another push and they get another stretch...

Asked if she believed that the use of visualizations can have a physical effect, Rosemary stated, "Absolutely! You can see it happen, when they are at a certain point, you say no, its not going to stay and they will give it another push and they wil' et another two inches of stretch, overcoming any pain or any tension they might have had, purely by thinking of what they are doing, putting themselves in that box or in that room." She also suggested that with one of her patients she was able to demonstrate a measurable increase in muscle strength using visual imagery.

During my conversation with Rosemary, I teased her about her reticence to discuss her use of imagery in the treatment of her clients with her colleagues which up until 1992 included me! I asked her why today, was

she more comfortable in discussing its use?

Yes. I quietly did it on my own until recently when people are asking me what do you do, and now that there is a trend to more alternative medicine you feel quite safe in discussing it. Ten years ago I never would have said I used it for strengthening!

In her view, the impact and in some instances the incorporation of some of the alternative medical practices into the western medical practices has created a tolerance for a practice such as visualizations. Some of the modalities of alternative medicine such as acupuncture and reflexology, although not incorporated into the physiotherapy school curriculum are now being sought out, extracurricularly, by physiotherapists. As she states:

Physiotherapists go and learn them. Yes, reflexology, acupuncture, things they were quite dubious about before.

In addition, Rosemary feels that imagery is being used in the context of relaxation and pain relief more now in physiotherapist practices.

In this, my third interview, I still found myself unable to follow Bernard's advice! Bernard cautions the anthropologist:

Don't substitute tape for notes, and don't wait to go home to take notes either. Take notes during the interview about the interview. Did the informant seem nervous or evasive? What were the physical surroundings like (Bernard, 1988:219)?

So far I have been unable to take notes during the interview; I find it extremely distracting. I am a good listener, an attentive one. I tried to scrawl a few words on my notepad during my interview with Cathy, but I found it disrupted my listening; it sidetracked me. I have to listen attentively in order to ask the appropriate questions. So I wrote nothing more. However, I made mental note of Cathy's demeanour during our interview. It was one of calmness, earnesty and confidence. I took Bernard's advice and didn't wait to go home before I wrote this down on paper. Instead, tongue in cheek, I wrote it down when I returned to my car!

Physiotherapist Cathy McCaffery

Cathy McCaffery, another of my former colleagues at the Arthritis Society who is presently working as a physiotherapist at the Civic Hospital here in Ottawa, told me that she first encountered the use of visualizations in

the practice of physiotherapy when she was working in Victoria, in 1987. One of the physiotherapists there, was using guided imagery in his practice. According to Cathy, he had shown a strong interest in alternative medical modalities, including reflexology, acupressure, and imagery. He described guided imagery as using the subconscious to communicate with the body. After he arranged a workshop on its use, other therapists also began to use visualizations in their practices. Primarily, visualizations were used for pain relief in patients with chronic conditions, and in the deep breathing exercises given to post-operative patients. Cathy described the use of imagery in the management of pain.

You visualize your pain as a ball in front of you and you give it texture, colour, and weight and consistency. You start to ask what colour is it, how heavy is it, is it the same colour all the way through, and then you start to work with it and soften it and you put it in a beaker and you stir it up and gradually it evaporates and with your magic wand it disappears! So its acknowledging the pain, dealing with it, externalizing it, and then getting it to go away. For someone with chronic pain its a very good imagery and I have used it occasionally with patients now.

In using imagery in breathing exercises, patients were instructed to take a deep breath, smelling the flowers or the freshly baked apple pie. In using this imagery, (olfactory imagery in this instance) Cathy maintained that it changed the deep breathing exercises "from a painful situation to a positive pleasant sort of environment." She proposed that

the idea was taking the mind away from the pain and putting it to something positive. So it was doing two things, one was a distraction in giving your mind something to think about rather than thinking about the pain and secondly, it works through the subconscious to tell the body that it could be well again and to work toward this other goal. Focus on being well rather than focusing on being ill.

When she worked for the Arthritis Society, Cathy used guided imagery which included visualizations, as a way of controlling pain, promoting relaxation, and getting her patients to focus on being well. In her view it did this "by decreasing muscle spasm, because when they are anxious and stressed there is more muscle tension which causes more compression within the joints which causes more pain, both joint pain and muscular pain, as a way of breaking into the pain cycle... and by focusing on the positive and feeling well." Used in this way, visualizations had specific physical effects. When

asked if she felt that visualizations might have an effect on the underlying disease process itself, Cathy replied that she did not know.

According to Cathy, the use of visualizations and other types of imagery is now part of the treatment program for people who are being seen by The Arthritis society therapists. She maintains that for the past three or four years, the Ontario division of the Arthritis Society has had tapes on relaxation, including some with various types of guided imagery. These tapes are available to local offices such as the Ottawa branch. Cathy herself used several different tapes which included imagery in them. "One of them was an image of being on clouds and stepping through the clouds and that was a different one than I had used before."

Feeling uneasy, I headed to the Regional Hospital in Hull, Quebec to talk with Donald Grenville, a cancer specialist who had kindly agreed to be interviewed about his thoughts on visualizations in the treatment of cancer. My sense of unease was based on the possibility of his hostility towards visualizations and my response to it. It was also based on the fact that I knew he was extremely busy, with many patients to see. All through the interview this thought niggled in my mind, contributing to my sense of having to hurry. Yet, Grenville himself seemed patient, curious, accommodating. Aware of my feelings, I thought to myself. Yes! Feelings of the researcher do affect the research process!

During my interview with Grenville, I experienced Bernard's admonishment to keep your interview open ended enough to follow new leads. Bernard argues that even in a semistructured format where you have an agenda, you should provide a space for new leads to occur. What happened in the interview with Grenville was unexpected. Just as the interview was winding down, spontaneously, I asked him if he had anything else to tell me. Immediately, he began to discuss unconventional medicines in the treatment of cancer. I had the sense that he had come into the interview with this topic on his mind. I was so glad that this question had just popped out of my mouth! I would have missed a valuable, personal perspective on this topic!

Oncologist, Dr. Donald Grenville

Dr. Grenville an oncologist who has been in practice for ten years spoke

to me about his views of visualization therapy. When asked whether his patients used visualizations as part of their treatment of cancer, he replied that indeed, they did. Perhaps as many as one third of his patients under active treatment for cancer used some sort of imagery. His attitude towards visualizations is such that when he discovers that a patient is using them he says:

I tell them keep doing it, but in terms of promoting it, I don't but I don't demote it. If they say they are doing it, I say fine.

In his view, its value lies in the fact that "it sort of helps them deal with their cancers as opposed to having any objective effect on the cancer. He sees no evidence that visualizations have a curative effect. He states that:

to be curative it would have to be looked at and to my knowledge nobody is looking at it. Maybe someone is looking at it, but not in a phase three trial- like objective study. Nobody is looking at it that I know of, and until you look at it you can't say something has ...an ability to promote a tumour shrinkage...."

In his treatment of people with cancer, he takes a physically based approach, an approach which he says is typical of his colleagues.

I think...you treat cancer with the surgery and then whatever, radiation, chemotherapy, the pain killers. You know basically, you don't have much time to chat with these patients, at least I don't. So maybe they want to discuss this but you know I'm at the door! You know you can't. Besides there's no proof that it (visualizations) works, there's sort of angels dancing on the head of a pin....

I asked Grenville if he had noted changes in treatment during his ten years in practice. For example, was there a more multidisciplinary approach to patient care today, in order to deal with psychosocial aspects of care? Were there new forms of physically based treatment? His response to the question concerning a more multidisciplinary approach, was no, at least not in the structured sense. Social workers, nutritionists, psychologists, and nurses were available to those who entered active treatment on a casual basis. However, Grenville argues that this situation will change for the worse as cut backs affect the hospital personnel. He states:

I think less, you know why? There is no money, because these people are not hired; the hospitals have downsized. So ten years ago there would be a lot more patient attention I think. The nurse would chat with the patient or discuss things...the social worker would discuss the

patients' problems....

Concerning the question about new forms of treatment, Grenville's response was that while some changes had taken place, there had been no major breakthroughs. He stated that

bone marrow transplants have become a very commonly accepted procedure for all kinds of cancer. But the reality is most of what we do, we did ten years ago, over ninety percent I'm sure. On a day to day basis things haven't changed much. There hasn't been that much progress.

When I asked Grenville whether there is a resistance among his medical colleagues against the use of visualization therapy, he said:

No. There is no resistance. The only thing is you have to look at what we do in the economic context that we operate in. You know most docs in North America are fee for service....You see the patient and out the door they go once their immediate problem is taken care of, and you know they might ask about this and you say I don't know anything about that. Good-bye. Basically, its just not part of the interview. It doesn't get on the agenda!

Nearing the end of the interview, spontaneously I asked Grenville if he had anything further to say. Immediately, he began to tell me that the use of unconventional medicine in the treatment of cancer "is becoming an item", a fact he found disturbing. His concern relates to the fact that he could find "no objective evidence that these medicines work." He told me that many of his patients were taking herbal medications such as Essiac. He argued that "there is not a shred of evidence that they work. In fact I'm sure it doesn't work." Elaborating, he mused that over the course of decades you would think there would be something, even anecdotal evidence it works. When I suggested that such anecdotal evidence was out there, he responded by saying: "But not objectively anecdotal, like you know, where you had some doctor look at the evidence before and after." He argued that when the patient attributes the disappearance of his or her tumour to the herbal medicine Essiac, perhaps it never was a tumour in the first place. He stated: "Maybe it was a cyst and it would have disappeared in any case." He concluded: "I think you have to objectify."

Welcoming me into her office which was tucked away on the fourth floor of the cancer clinic of the Ottawa Civic Hospital, Jill Reinhart motioned

me to sit down in the comfortable high-backed armchair. No, she didn't mind my taping our interview, words I was relieved to hear, as I had forgotten to ask her permission when I had called to set up our interview! Bernard would have had the last word, I thought to myself! I would have been forced to take notes on site! In this, my last interview, I was determined to 'make noteworthy' the physical setting in which I found myself. Hammersley and Atkinson warned that as an inherent part of the research process, the researcher's personal responses will inevitably influence one's choice of what may, or may not be noteworthy.... In my case, the physical settings in which my interviews have taken place have been, to a large degree, outside my level of awareness. It's a personal idiosyncrasy. I rarely notice people's furnishings. A cultural familiarity of most of the settings, I'm sure also plays a part in my lack of awareness of these things. The kind of blindness that Burgess talked about when anthropologists work in their own culture. At the same time I am very aware of peoples' facial expressions, body language, and general demeanour. Again, a personal characteristic. (Perhaps a survival skill for a kid who moved around a lot?) A few minutes into the interview, my attempt to instill the physical surroundings in my mind dissolved as face to face with Jill, I leaned forward to hear her words. The tape recorder's red light beamed reassuringly...

Jill Reinhart Social Worker at the Ottawa Civic Hospital Cancer Centre

Jill Reinhart was first introduced to the power of visualizations in 1980 when she treated five patients undergoing kidney transplants with sessions of relaxation and imagery, prior to their surgery. These patients experienced a lower incidence of rejection which is a normal part of the transplant process; everyone expects it. Five years ago she applied for, and was accepted for a position which was being created by the Cancer Centre to develop programs for women with cancer. When I asked her why these programs would include one with visualizations, that is, what had happened in the community which allowed this practice to emerge, she responded by saying:

I think its largely because of Bernie Siegal and those guys who popularized it... There was a shift to bring the mind and body together. Its still going on. You know the split that happened with Descartes where you split the mind and body. Medicine has always proceeded

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...and, yes, Chris' tumour got smaller for many months, and she eventually tripled her prognosis. But, best of all, she really started living again.

From the perspective of biomedicine then, if its goal is the extension of life and it perceives that the mind cannot bring about that outcome, it rejects *any* role for the mind in the contributing to health. Instead, it falls back on its doctrine of mind-body dualism. Brigham(1994:49) quotes Achterberg and Lawlis who lament the focus of biomedicine on extension of life as the primary goal. They state:

The psychosocial aspects interventions and cancer research have trod an unfortunate path by representing life expectancy as the primary goal, devaluing any qualitative outcome. We would argue that increasing the length of life as a goal pales by comparison to living with grace, clarity, and meaning (however, one defines these values).

Having discussed this notion of 'blame the victim' which emerged from my fieldwork, I now examine a second finding which surfaced in my interviews. This issue relates to the fact that according to Reinhart, (and substantiated by cancer patient Osprey) most patients who attend her coping skill classes in which they learn to do visualizations or other forms of imagery, abandon this process soon after their fear subsides and their active treatment ceases. As Reinhart states:

When they are really scared and first come into my coping skill courses, oh yes, yes, yes, and they buy the tapes. I don't think one percent actually practice their imagery because people aren't disciplined....I don't think most people are willing to change their lifestyle....

The question arises as to why this is so? Why don't these patients with a life threatening disease such as cancer, continue to embrace visualizations as integral to their treatment? Why do they stop doing them? Is it because, as Reinhart says, they are not disciplined enough? No. I argue that these patients abandon their visualization therapy because they do not understand the physical effects of visualizations. Rather, they have been enculturated into the mainstream medical view that while visualizations, as well as other psychosocial forms of treatment can affect the quality of life they cannot extend it. Since these patients do not accept that visualizations have physiological effects, they are not motivated to continue to do them. Therefore,

In her work with cancer patients, Reinhart provides them with the skills to cope with their disease. She states: "When life throws us curves we have a choice as to how we interpret that curve, whether we turn it into a positive or a negative and so really what I do is helping people to make choices." Then Reinhart threw me a curve! She said "all that imagery stuff, very few people are really interested in disciplining themselves to the imagery." Continuing, she said that

When they are really scared and first come into my coping skills courses, oh yes, yes, yes, and they buy the tapes. I don't think that one percent actually practise imagery because people aren't disciplined. I don't think people are willing to change their lifestyle, most people.

In theory they might, she asserts, but they say:

Its too hard, or I'm busy today. The dog is barking....Especially with women, I do a lot of work trying to teach women to start taking care of themselves.

Concluding, she stated

In my experience most people aren't interested. They might be when they are panicky, but the panic subsides after awhile, and if you have the normal course of a cancer treatment, usually you are better, at least for awhile. No one knows for how long. So once the panic abates, and you know you are not going to die tomorrow, you may say well, on second thought, that ice cream cone looks pretty good. You know, that seems to be human nature.

Despite her assertion that most people do not faithfully follow their visualizations, nevertheless she offers them as part of her coping skills class. Most of her sessions involving imagery are group sessions. She states that "I teach them the fundamentals of how to create an image, how one creates an image for yourself." Then, she guides them through an imagery process, one that is fairly generic. For example, she tells them to imagine a tranquil scene which appeals to them. The imagery content will vary, depending on the individual's definition of tranquility. She tells them to "visualize your treatment coming to your cancer cells, adding that "one person might see a white knight galloping, someone else might see a wolf." She suggests to her patients that they do their visualizations three times a day for fifteen minutes or twice a day for half an hour. She asks them to

instruct your unconscious to keep working on this until you get back to it again. Then you go back to it at the end of the day and you pick

up your imagery and instruct your subconscious to keep working on it. That's ideal, that's for people who really embrace the concept and have some discipline.

Reinhart was aware of the debate over imagery content which had one camp arguing that images should be symbolic while the other insisting that images should be anatomically correct, in order to be effective. Her personal view held that the more symbolic the imagery, the more effective it was in causing physiological changes. "If your images come up from your unconscious then they will have a much more powerful meaning to you and therefore more effective."

In response to my question whether or not she was aware of the Simonton's criteria for effective imagery she responded that she was not. However, Reinhart was cognizant of the fact that the use of visual imagery was not the mode of imagery for everyone. In helping her clients to create their imagery, she tested them, in order to determine what type of imagery was most suitable for them. She asked them

...to close your eyes and imagine a bell ringing, hearing a bell ring or can you see your house or can you put your hand under cold water. Then, we would go around the circle and people will say 'well I couldn't see anything but I could really feel the hand shake and could really hear the bell ringing.' So I'm saying, okay, your kinesthetic sense and your auditory sense are the ones you should use the most when you are developing your imagery for you. Someone else will say I could see but I couldn't smell anything. Smell seems to have gone....

When I asked her about her training for visualization therapy, she told me that she had taken several workshops on it, including John Shaffer's transformational fantasy which she said, made her aware of the symbolic nature of imagery. She was not aware of a formal 'school' for training imagery therapists in the Ottawa area, nor did she know of any structured association for imagery therapists here in Canada.

Another of my questions to Reinhart concerned the response of the oncologists and other medical specialists to the use of imagery in the treatment of cancer. Was it accepted by the medical community? No, she responded. "When I came here five years ago they would go ballistic, saying, 'What is this quackery!'" One of her workshops was threatened with cancellation because she had used the term, 'get in touch with your inner healer'. As a result the medical advisory committee went "insane", threatening to cancel this

workshop. She told them:

You've got to understand. These people know what I mean, what I'm saying here. Allow me to explain to you. It doesn't mean 'cure'.

At the same time, in response to their threat to cancel her workshop, Reinhart argued that if they "tried to cut this stuff out you might have a revolution....This is the 90's...patient power...." However, Reinhart says that she understood their predicament.

I have to say that truly from their point of view they were sincerely concerned because none of these things have been proven by the scientific criteria that they find acceptable and they have seen some people taken to the cleaners and I'm very wary also and I try to teach patients to be careful.

Today, five years later, according to Reinhart, imagery is much more accepted as a part of treatment by the physicians. They have become open to it, based on the positive reports from their patients. Although her support programs which includes visualizations are not seen as integral to treatment, Reinhart feels that it is more a manpower and economic problem rather than resistance from the medical community. As she states:

We do not have one hundred percent referral process. There are two of us at this centre and in this division over here we might see over four thousand new patients a year.

Reinhart says that both doctors and nurses refer to her groups, although its mostly nurses who decide who is really upset and needs a social worker.

In conclusion, Reinhart feels that there is a momentum gathering to include aspects of the mind in healing(which she cautions is not the same as curing) within the medical community itself. Even one of her most ferocious adversaries who, as she said,

...thought I was a 'dingbat', had another part of him thinking maybe she's onto something here. So he wasn't going to squash me completely. Cause a little niggler comes into his mind. Well, even if this isn't right this might be the trend. If I'm going to be politically correct, then I'd better not squash it.

In this, my first experience of fieldwork, three impressions predominate: Firstly, for the most part, I enjoyed the research process very

much. My enjoyment of the process relates to the fact that after pushing through an initial shyness, I enjoy meeting new people and finding out how they think and feel about an issue. I am a good listener; it is one of my strengths. Bernard says that "if you can carry on a non-threatening, self controlled, supportive, polite and cordial interaction in everyday life, then interviewing will come easy to you." (Bernard, 1988:207) Easy, maybe not, but enjoyable yes. Obstacles to my enjoyment concerned the use of the tape recorder (gaining confidence in it!) as well as taking notes while at the same time listening to the informant (still not overcome)

Secondly, I learned a lot about the research process itself: the techniques of interviewing, as well as the technology of interviewing. I realize that I have much more to learn but the motivation is there. Bernard discusses certain good interview techniques such as setting a context for informants to "open up and let them express themselves". This I found I was able to do. Also I discover that it was natural for me to use what Bernard calls a 'neutral probe', a technique where the researcher encourages the informant to produce more information by "making affirmative noises, like uh -huh or yes, I see." (Bernard, 1988:213) However, I also was very aware when my own words choked off further elaboration of an idea of the informant. Even at the moment my words tumbled out I realized the cost of my blunder. This happened during my interview with Rosy. Just when she was beginning to warm up and expand on her understanding of transformational fantasy, I jumped in with an experience of my own. There was no chance to recover. After my interjection, I noticed that Rosy had lost her train of thought. The moment had passed.

Thirdly, in my view, my fieldwork experience reinforced the validity of the reflexive approach to field research. My experience of the research process substantiated Hammersley and Atkinsons' notion that anthropologists are part of the research process such that feelings "enter into and colour the social relationships we engage in during fieldwork." The excitement and nervousness of my initial interview with Rosy very likely contributed to my tendency to interject my own experiences in the encounter at the most inappropriate time. My interview with Kim would have, I'm certain, followed a different course had she not eased my feelings of thirstiness and irritability with a cup of tea! For me, inability to concentrate and feelings of fatigue

result when these feelings predominate.

Hammersley and Atkinson also discuss how personal idiosyncracies help to determine what anthropologists find noteworthy, problematic or mundane, affecting both the process and the outcome of the research encounter. I suggest that my lack of attention to physical surroundings reflects a personal idiosyncrasy which may well have resulted in a lack of information about my informant, even, perhaps an important piece. As well, I suggest that my inattention to the physical setting, also stems from my doing research in my own culture. I have fallen into that pitfall of which Burgess speaks, a pitfall I was attempting to avoid. Namely, will researchers give full coverage to situations with which they are already familiar? Until I work on it, my response must be no!

As a result of my fieldwork, I had the opportunity to learn from a variety of individuals, their understanding and experiences of visualizations as they relate to health.⁴ In my conversations with these individuals, I came to understand their explanations of how visualizations came to be incorporated into Western biomedical practices. According to Reinhart the disillusionment with the technology of biomedicine played a strong role in the adoption of visualizations into medical practices. In Kinch's view, the incursion of some of the alternative medical therapies into Western medical practices made her feel comfortable in using and discussing visualizations in her own practice.

In the following chapter, I analyse my informants' understandings of visualizations and discuss several findings which have implications for the acceptance of visualizations as part of biomedical practices. In addition, I analyse my fieldwork from Bourdieu's theory of cultural change.

Chapter 5

Blaming the Victim

In this chapter I attempt to accomplish two goals. In the first section of this chapter I explore the correlations, discrepancies, and differences, between the information which I found in my research on visualizations, and that which I discovered as a result of my fieldwork. In addition, I discuss several issues relating to my informants' understanding of visualizations which I suggest have a strong impact on the acceptance or rejection of visualizations as a biomedical practice.

In the second section of this chapter, I analyse my fieldwork from the perspective of Bourdieu's theory of cultural change.

1. Fieldwork analysis

I begin by returning to the second chapter of my thesis, in which I presented criteria and guidelines for effective imagery, according to those therapists who used imagery with their patients, and I compare them with the those of my informants. In some instances, I note congruencies. For instance, informants Reinhart, Sperling, and Osprey all argue that being in a relaxed state is fundamental to the production of imagery. Sperling who does transformational fantasy with her patients concurs with Naparstek who is adamant that effective imagery is produced only in an altered state of conscious. In considering the criterion of whether or not symbolic images are more effective than anatomical ones in effecting change, Reinhart, aware of this debate comes down on the side of symbolic imagery. Sperling agrees, arguing that images are potent healers as a result of their symbolic nature. Their power to heal, be it physically or emotionally, she asserts, derives from their symbolic nature.

Like Brigham and Naparstek, informant Reinhart is cognizant of the fact that imagery has moved beyond the sole use of visual imagery to include the other sensory paths. In fact, Reinhart has devised her own test to determine which type of imagery a patient would find most appropriate. I note, too that Sperling has adopted the psychoneuroimmunological perspective to explain the impact of imagery on the body, like that of Brigham, Achterberg and Naparstek. However, the specific imagery for

arthritis patients advocated by Brigham or Naparstek are not followed by physiotherapists Kinch or McCaffery. Nor, are the detailed, personalized assessments given by Achterberg to her patients prior to their visualization sessions carried out by informant Reinhart.

Having briefly discussed some of the congruencies and differences between my informants' visualization or imagery practices and those discussed in my literature search, I now discuss three findings from my fieldwork which I suggest has important implications for the acceptance or rejection of visualizations as a practice within the field of biomedicine. The first and second findings concern the relationship between visualizations and North American understanding of biomedicine's doctrine of mind-body dualism, while the third issue relates to its epistemology.

The first finding raises an important issue concerning how visualizations and other mind-related practices are understood in relation to health and disease by some cancer patients, physicians, and indeed, perhaps by the general public. This finding has challenged those in the health field who call for an explicit acknowledgment of the links between cognitive, psychological, and emotional mind states, and health. The finding to which I refer, relates to comments made by Osprey and Reinhart. Osprey argues that many advocates of mind/body healing using techniques such as visualizations, assert that if the mind has the power to heal the body, then conversely it may also create disease. From this idea, patients draw the conclusion that a person who becomes ill, has caused his or her illness by negative emotions or thoughts, and should be blamed for its onset. Osprey states:

There are a lot of patients out there who only think negatively and they think if even one negative thought crosses their mind, they are going to jeopardize themselves. When a person gets an illness, the first thing they think is 'what did I do wrong?'

Moreover, as the belief goes, by changing your beliefs and attitudes, you should be able to cure yourself. If you don't you are to blame. As Reinhart states:

People, like Siegal were saying, if you have the right attitude, you can cure yourself which puts an awful lot of blame on the patients, and I saw some people badly hurt...Cancer is a complex disease. There are too many variables.

This attitude of 'blame the victim' has, as Reinhart has said, caused

heartache to some patients. This notion has also been seized by those who adhere strongly to the doctrine of mind-body dualism as a way of discrediting those who seek to bring the influence of the mind into the healing process. As well, it has been used to as a weapon to discount any notion that the mind has any contribution to make in matters of health.

For example, in an editorial in the New England Journal of Medicine(1985), Dr. Marcia Angell argued that many of the current mind/body beliefs were not only scientifically unjustified but also were actually damaging to patients with serious disease, since these beliefs promoted 'false hope' and 'guilt' in these patients. Angell argued that when a patient is led to believe that he or she has control over his or her illness then a sense of false hope is instilled in the patient. This in turn leads to a sense of guilt in those patients who do not progress, causing them to blame themselves (Brigham,1994:49). Moreover, she argued that

if the patient's family members, physicians, etc. also hold the mind-body beliefs promoted by psychoneuroimmunology, they may begin to blame the patient for lack of progress, too. Soon this 'blame the victim' attitude may be evident in their behaviour toward the patient; in worst case scenarios, it may even be verbalized to the patient, with unthinkable results(Brigham,1994:49).

Angell's thoughts resonate with the statements given earlier by informants, Osprey and Reinhart.

In her attempt to deal with this challenge to those who call for a mind-body approach to treatment of illness, Brigham makes several arguments. First of all, she argues that we need to acknowledge that guilt may in fact be a side effect of "psychoneuroimmunology(PNI) strategies". Yet, as she argues, one does not necessarily give up a treatment because of its side effects.

Brigham(1994:51) states:

As Norman Cousins pointed out, physicians do not give up in prescribing chemotherapy because patients suffer the side effects of nausea, hair loss, etc. Noting that radiation or chemotherapy treatments for cancer do not always work, he asked, 'Should a person feel guilty because the treatment worked in someone else and not in him?'

Continuing, Brigham makes a second argument, one that relates to Osprey's statement in which Osprey says: "There are a lot of patients who only think negatively and they think if even one negative thought crosses their

mind, they are going to jeopardize themselves". According to Brigham, this view typifies western culture's 'all or nothing' type of thinking. She(1994:51) states:

Our society tends to have a very simplistic ideas of cause and effect: When we are faced with an effect, there must be a cause- a single cause.

Whereas, Brigham argues that there is an "extremely complex web of causality for 'lifestyle' diseases such as cardiovascular disease, cancer, and diabetes"(Brigham,1994:52). Informant Reinhart presents a similar view, in her statement: "Cancer is a complex disease, there are too many variables". I suggest that this understanding of the causality of disease by patients, physicians and the public is a manifestation of two tenets of biomedicine, both of which I referred to earlier in my thesis : that of the single cause theory and the epistemology of reductionism.

Furthermore, Brigham(1994:50-60) suggests that part of misunderstanding between the adherents of the biomedical model who reject the view that the mind can contribute to health, and those within behavioural medicine who hold the reverse argument, stems from the fact that each camp has a different goal for the patient. For many biomedical practitioners, the goal is to cure or to eliminate the disease and thereby to extend life. Whereas, for those mind-body practitioners, their goal may be to *heal* the patient, a goal which does not necessarily mean to *cure* the person. Informant Reinhart, makes this point in her statement in which she argues that there is a momentum gathering to include aspects of the mind in healing, cautioning me to be aware that healing is not necessarily curing. Rather, mind-body health practitioners such as those within the field of psychoneuroimmunology(PNI) or in the alternative systems of medicine are concerned as well, with the quality of life of the patient; they wish to bring about healing in the deepest sense. Healing considers the emotional, psychological, spiritual aspects of a person and is concerned with making the person who is ill, well or whole in all these areas, even if in fact, the person is not cured of his or her disease. Indeed, from this perspective, the person who has cancer may be healed yet die. Recall Brigham's patient, Chris, the jazz pianist who began playing her piano again when she composed an auditory imagery to combat her cancer. Brigham(1994:14) reveals this understanding of healing in her statement:

...and, yes, Chris' tumour got smaller for many months, and she eventually tripled her prognosis. But, best of all, she really started living again.

From the perspective of biomedicine then, if its goal is the extension of life and it perceives that the mind cannot bring about that outcome, it rejects *any* role for the mind in the contributing to health. Instead, it falls back on its doctrine of mind-body dualism. Brigham(1994:49) quotes Achterberg and Lawlis who lament the focus of biomedicine on extension of life as the primary goal. They state:

The psychosocial aspects/interventions and cancer research have trod an unfortunate path by representing life expectancy as the primary goal, devaluing any qualitative outcome. We would argue that increasing the length of life as a goal pales by comparison to living with grace, clarity, and meaning (however, one defines these values).

Having discussed this notion of 'blame the victim' which emerged from my fieldwork, I now examine a second finding which surfaced in my interviews. This issue relates to the fact that according to Reinhart, (and substantiated by cancer patient Osprey) most patients who attend her coping skill classes in which they learn to do visualizations or other forms of imagery, abandon this process soon after their fear subsides and their active treatment ceases. As Reinhart states:

When they are really scared and first come into my coping skill courses, oh yes, yes, yes, and they buy the tapes. I don't think one percent actually practice their imagery because people aren't disciplined....I don't think most people are willing to change their lifestyle....

The question arises as to why this is so? Why don't these patients with a life threatening disease such as cancer, continue to embrace visualizations as integral to their treatment? Why do they stop doing them? Is it because, as Reinhart says, they are not disciplined enough? No. I argue that these patients abandon their visualization therapy because they do not understand the physical effects of visualizations. Rather, they have been enculturated into the mainstream medical view that while visualizations, as well as other psychosocial forms of treatment can affect the quality of life they cannot extend it. Since these patients do not accept that visualizations have physiological effects, they are not motivated to continue to do them. Therefore,

before long, they abandon them.

This notion that psychological or social interventions may affect the quality of the cancer patients life is a relatively recent development. Lerner states that over the past twenty years psychological approaches to cancer have emerged in mainstream medicine, resulting in a new subspecialty called psychooncology. Its focus has been to research and develop treatment strategies, such as progressive muscle relaxation training, imagery, hypnotherapy, as well as other stress reduction techniques that can reduce the side effects of cancer treatment, including symptoms which may be associated with cancer, such as pain, sleeplessness, and weight loss(Lerner,1994:138-44). In my literature search in medical and psychological journals on the use of visualizations I was able to confirm this focus of research. As examples, I found articles on cognitive-behavioural interventions in management of cancer pain, on the use of visualizations in alleviating depression and/ or anxiety in cancer patients, and relaxation techniques using guided imagery to control conditioned side effects of chemotherapy such as nausea and vomiting. Likewise, in my literature search into the use of visualizations in the treatment of arthritis, I discovered a similar finding, that is a cognitive behavioural approach to the treatment of rheumatoid arthritis pain. This finding correlated with my fieldwork in which for example, McCaffery, used the fragrance of apple pie to encourage her post -operative patients in their deep breathing exercises. The exception was Kinch who argued that the use of visualizations produced a measurable strengthening effect on the weakened muscles of an arthritis patient.

Thus, psychooncologists focused their research and treatment on psychological/social strategies which would show an improvement in the quality of life of the cancer patient. They did not concern themselves with the issues of whether or not psychological strategies, such as group therapy or imagery, might extend the life of the cancer patient. Lerner(1994:142) presents his reasons for this situation. He argues that by and large, psychooncologists have worked in a biomedically based settings which give low status to psychosocial issues. In these settings the primary focus of treatment is on procedures such as surgery and chemotherapy. Lerner gives his own example of the distance between oncologists who focus on psychosocial aspects of cancer and other more biologically based oncologists:

I vividly recall one of the most rigorously scientific and best respected researchers in psychooncology, who holds a distinguished position at a major teaching institution, telling me how a senior surgeon asked him about his work and, after listening briefly, had said to him: 'you don't really believe all this bullshit, do you'(Lerner,1994:142)?

As a result of such attitudes within the biomedical community psychooncologists avoided conflicts with the more physically based specialists by focusing their attention on quality of life issues for cancer patients, rather than on issues of life extension. As Lerner(1994:143) states:

In order to minimize conflict with the cancer treatment specialist, until very recently practitioners of psychooncology have presented themselves almost exclusively as the facilitator of patients' better adaptation to cancer, cancer treatment, cancer progression, or cancer survival....For many years, most psychooncologists strongly disclaimed any suggestion that their methods might contribute to life extension, or the likelihood of cure.

Lerner observed that the cautiousness of the psychooncologists was in contrast to "the aggressive research agendas of specialists in other fields of cancer treatment who were seeking life extension using techniques such as bone marrow transplantation, endocrine therapy, and immunotherapy"(Lerner,1994:143).

Recalling my interview with Grenville, I suggest that Grenville may typify the oncologist who bases his treatment on physical measures. He said that you "treat cancer with surgery, and then whatever, radiation, chemotherapy, then painkillers". According to Grenville, he had no time for the psychosocial aspects of cancer, due he said to time and money restraints; he was "at the door" when these issues were brought up by the patient. In terms of visualizations, he said that he neither 'promotes' nor 'demotes' them, seeing visualizations as a means of coping with cancer rather than curing it. As Grenville stated earlier:

To be curative, it would have to be looked at, and to my knowledge nobody is looking at it. Maybe someone is looking at it, but not in a phase three trial-like objective study. Nobody is looking at it that I know of, and until you look at it you can't say something has ...an ability to promote a tumour shrinkage....

In this statement Grenville raises the third issue of my fieldwork which I examine more closely. This issue concerns Grenville's insistence that in

order for visualization therapy to be considered a valid treatment, it "must be substantiated using three trial like objectivity". Also, further in our discussion, Grenville discounts the efficacy of the herbal medicine Essiac, saying: "There's not a shred of evidence they work.... In fact I'm sure it doesn't work". Firstly, I suggest that in his statement, Grenville's is reflecting the epistemology of biomedicine which uses a scientific methodology to validate its knowledge. In the world of biomedicine, the gold standard of valid knowledge is considered to be the randomized controlled trial. Secondly, Grenville's statement reflects a mistaken belief held by many biomedical practitioners: that all their medical treatments have been validated using this scientific methodology. "Not so". say Brants and Gugeler(1995:A13) " Less than 20 per cent of mainstream medicine is based on clinical trial".

Despite Grenville's statement that he is unaware of any clinically based, scientific trials on the efficacy of visualizations, in fact, such studies have been conducted. However, until recently, these studies were not randomized clinical controlled trials. Thus, their conclusions were suspect. In his latest book, *The Healing Journey*, Carl Simonton(Simonton and Henson,1992:5) states:

From 1974 until 1981 we conducted a seven year outcome study of our patients and found their term of survival to be twice as long as the survival times reported from other leading cancer centers, and more than three times as long as the national average for survival of people with similar advanced cancers.

Elaborating, he stated that due to lack of funding, "they could afford to do it[these studies] only on their own patient population, a selected group, without the randomization and a matched control population, necessary for maximum scientific credibility"(Simonton and Henson,1992:5).

In 1984 Cunningham of the Ontario Cancer Institute reviewed the studies which consider whether or not psychological interventions can change the course of cancer. Aware of the methodological deficiencies of these clinical studies, nevertheless, he found that the results of these studies showed a consistency with each other. He argued:

This broad consistency points to a possible core of validity. It indicates at the very least, that the clinical claims should not be dismissed on methodological grounds and that the time has come to subject the claims to 'properly controlled' clinical trials(Lerner,1994:153).

Recently such a study was done. In what is being considered a landmark study, David Spiegel a Stanford university professor presented the results of a randomized controlled study which provided the biomedical community with solid scientific evidence that psychological interventions can extend life. Irritated by the 'overstated notions about the power of the mind over disease', Spiegel revisited a randomized controlled study which he had conducted ten years previously on eighty-six women with metastatic breast cancer. In this study the women had been randomized into two groups. One group received standard medical treatment while the other group received the standard medical treatment plus weekly group therapy sessions, as well as self hypnosis which included relaxation and imagery. In revisiting his study ten years later, Spiegel looked at the survival times of the women, expecting to refute the claims of those adherents of the 'power of the mind over disease'. Instead, he found that the women in the intervention group had twice the survival time of women in the control group. At the ten year point eighty-three of eighty-six women in the study had died. But the women who received group therapy lived an average of 36.6 months after entering the program, while those in the control group lived an average of 18.9 months (Lerner, 1994:155; Spiegel, 1991:15-16).

According to Lerner this was a landmark study not only because of *what* it found, and the implications for the medical establishment, but also *who* Spiegel was: a professor of a prestigious university who had undertaken the study without any preconceived notion that a psychological intervention could extend the life of a person with cancer. In fact, his bias was of the opposing view: these interventions could not extend life.

The Spiegel study has given substantial scientific support to mind-body claims such as those within the PNI movement. Yet according to Brigham, acceptance within the medical establishment has been slow. Agreeing, Lerner states: "Yet, had this been a new chemotherapy, do you want to guess how big the headlines would have been and how much the National Cancer Institute money would have been poured into the replication of that study" (Brigham, 1994:27)?

In the analysis of my fieldwork on visualizations in the treatment of cancer and arthritis, I have discussed three issues which relate to the understanding of visualizations by my informants. I have looked at the issue of

blame and guilt of cancer patients who have used mind-body therapies such as visualizations. I have examined Reinhart's revelation that most of her patients abandon their visualizations after their fear and active treatment cease. Finally, I have considered oncologist Grenville's concerns about the need for scientific validation of visualization therapy claims that they can play a role in curing cancer before they are accepted as a valid form of treatment of cancer.

In my view this analysis has revealed the continuing grip of biomedical tenets on many patients' understanding of visualizations and other mind-body treatment modalities. From my research, it appears that they have been well and truly enculturated into their model of health and disease, particularly with regard to the concept of mind-body dualism. For example, I suggest that Reinhart's patients(including Osprey)who abandoned their visualizations manifest biomedicine's doctrine of mind-body dualism which argues that the mind cannot, explicitly, effect bodily changes in the direction of health. These patients did not believe that their mental states could effect physiological changes in their cancer and therefore were not motivated to continue them. Moreover, those patients whodid adhere to the influence of the mind on the body and experienced feelings of guilt and blame when they were not able to rid themselves of their cancer, illustrates I suggest, biomedicine's epistemology of reductionism which looks for a single cause to explain disease.

From Grenville's perspective, the treatment of cancer focuses primarily on physical measures, manifesting the biomedical premise that the cause and cure of disease has essentially a biological basis. Although Grenville tolerated the use of visualizations, it was a tolerance based on the understanding that visualizations might make the person better able to cope with side effects of treatment such as pain or anxiety. He denied their ability to produce physiological changes in a tumour. This stance, I suggest is in keeping with the doctrine of mind-body dualism which states that the mind has no explicit role in effecting bodily changes, particularly as it relates to changes in the direction of health. Furthermore, Grenville's insistence on objective studies in order to accept a role for visualizations in the treatment of cancer exemplifies another biomedical tenet which argues that valid knowledge must be arrived at through scientific methodology, ideally that of a randomized

controlled trial.

In considering the implications of this analysis, I suggest that it raises several questions concerning the role and acceptance of visualizations in the treatment of cancer and arthritis. This analysis seems to suggest that biomedicine permits a restricted role for visualizations, one that is congruent with the notion that mental strategies may affect emotional states and coping skills for those with cancer or arthritis, but one that does not transgress its principle of mind-body dualism which argues that visualizations cannot effect the physiological processes of cancer or arthritis. Perhaps the reasons for this restricted role may become clearer when in the following section I examine these and other issues which emerged as a result of my fieldwork, from the perspective of Pierre Bourdieu's theory of cultural change.

2. Analysis of my fieldwork on visualization therapy from the theoretical framework of Pierre Bourdieu

In this section, I analyse my fieldwork on visualizations from Bourdieu's theory of social change, attempting to relate biomedical practices and their relationship with visualizations to Bourdieu's theory. However, before I begin this examination, I would like to confront a problem which arises in relation to Bourdieu's methodology and that of my fieldwork. Bourdieu argues that the focus of study in anthropology/sociology should be on relations amongst groups within society rather than on interactions amongst individuals. Whereas in my fieldwork I have focused on individuals and their views on visualizations. However, I am considering these individuals as representative of particular groups such as oncologists and visualization therapists.

In his analysis of culture, Bourdieu proposes that society is an aggregation of relatively autonomous social spaces or *fields*, where social agents occupy different positions vis a vis power. He defines *field* as:

a set of objective, historical relations between positions anchored in certain forms of power (or capital)....It is a network... of objective relations between positions....These positions are objectively defined, in their existence and in the determinations they impose upon their occupants, agents or institutions, by their present and potential situation in the structure of the distribution of species of power (or capital) whose possession commands access to the specific profits that are at stake in the field, as well as by their objective relation to other positions (domination, subordination, homology,)(Bourdieu and Wacquant,1992:16,97).

As a result of my fieldwork, I suggest that oncologist Grenville and health practitioners such as Reinhart and Sperling form a social space or *field* which can be objectively defined by social structures such as cancer clinics, doctors' offices and operating rooms. In this field each occupies a different position in terms of power. In this instance, I suggest that Grenville, as representing medical specialists is dominant in the field while those individuals such as Reinhart and Sperling who represent paramedical groups are in subdominant positions. Presently, using biomedicine's control of economic and symbolic capital (please see page 61), Grenville is able to maintain the primary focus of cancer treatment on the body. Surgery and chemotherapy are the principle forms of treatment; psychosocial dimensions of treatment such as visualizations are at the periphery. Grenville's attitude towards visualizations is one of passive acceptance: He neither promotes nor demotes them. His central focus remains: "I think you treat cancer with surgery and then whatever, radiation, chemotherapy, the pain killers".

In his concept of *field*, Bourdieu has proposed that it is a space of struggle and contestation, as groups who occupy different positions relative to power, contest with one another in an attempt to gain or to preserve control over the type of capital which is dominant and operative in the field. I suggest that Reinhart's early confrontation with the hospital administration after her coping skills course was introduced to the clinic, illustrates the contestational aspect of field. Certainly, Reinhart grappled with these groups to have her coping skills classes accepted. She spoke of their initial resistance to her program, stating that they viewed it as quackery. During one of her workshops when she used the term 'inner healer', it was threatened with cancellation.

Yet, despite Reinhart's initial struggles with the more traditional medical community within the cancer clinic, I argue that visualizations have been included in as a part of the cancer clinic services. Furthermore, based on my fieldwork, I argue that they have become part of biomedical practices. For example, informants Reinhart, Osprey, Kinch and McCaffery, and Sperling now teach (or do) visualizations to their patients. In addition, Grenville tolerates visualizations in his practice and in doing so acknowledges a holistic approach to the treatment of his patients. Reinhart herself, has stated that over the past five years, visualizations have become more accepted by

physicians as part of treatment. The question arises, how did this change come about?

I suggest that one answer may be found in Bourdieu's concept of habitus, specifically its second aspect. In this aspect, Bourdieu defines habitus as:

an open system of dispositions that is constantly subjected to experiences, and therefore constantly affected by them in a way that either reinforces or modifies its structure. It is durable but not eternal(Bourdieu and Wacquant,1992:131-133).

According to Bourdieu then, habitus can be modified through experiences of alert, reflective individuals as they go about their daily activities, or as Bourdieu says, "via the organized artful practices of everyday life"(Bourdieu and Wacquant,1992:9). I suggest that my informants give evidence of this aspect of habitus. For example, oncologist Grenville observed in his patients that visualizations "sort of helps them deal with their cancers", leading to his tolerance of them. Reinhart's experiences with the use of visualizations in the treatment of kidney patients led her to realize their value. Similarly, Kinch and McCaffery, after observing the effects of visualizations on other patients, began to use them with their own clients.

So far, I have suggested that a change in habitus led my informants to accept visualizations, as well as other psychological and social strategies as having a role in biomedical practices. However, I would now like to introduce two other factors which I argue have played a strong role in the incorporation of visualizations into biomedical practices. The first factor relates again to the notion of habitus while the second relates to the aspect of capital which Bourdieu describes " as a stake of struggle that which allows its possessor to wield a power, an influence, and thus, to exist, in the field under consideration, instead of being considered a negligible quantity"(Bourdieu and Wacquant,1992:98-99).

With regard to the first factor, I suggest that a change in habitus of the public, brought about by its experiences with biomedical community has led it to seek out phenomenon such as visualizations and other mind- related activities in an attempt to make themselves better. Reinhart has told us that people have become disillusioned with the high technology of medicine of medicine and its body focused, reductionist approach to treatment. As Reinhart states:

I think people are realizing that technology isn't the answer, that even though our technology is so terrific. Doctors are not God, that even though they have all this high powered stuff people still die, people still suffer and what can we do to try to relieve that... So I think first this shift had to come to take technology off its pedestal, and then people started looking what else can we do?...Well, I guess I'd better start looking after myself a little bit...and that was when all this other stuff that had been out there before...Look! I think Bernie Siegal's approach changed the whole thing.

Therefore, as a result of these experiences, some of the more observant and reflective patients have modified their beliefs and practices around illness. While cancer patients continue to accept surgery and chemotherapy, they also have begun to explore those practices such as group therapy, visualizations, and relaxation techniques which could help to make them better and provide them with a more holistic framework of health care. In doing so they become participants in programs, such as Reinhart's. This change in patients' habitus, brings into high relief the second factor which I argue accounts for the use of visualizations in biomedical practices: the use of capital as a stake in the struggle between two groups.

We need to recall that the patronage of the public and its esteem is a form of symbolic capital which biomedicine has wielded as a weapon in order to maintain its power to define the western model of health and disease. However, as some of its capital diminishes as a result of patients' change in habitus, I suggest that this second function of capital becomes apparent. The public's (and patients) patronage and esteem have become a stake in the struggle between Reinhart and her hospital administrators and doctors in the cancer clinic to influence medical beliefs and practices. I argue that both Reinhart and her hospital biomedical community have come to understand public patronage in this way. In her response to the threat of cancellation of her workshop Reinhart warned the administration that if they carried out their threat, they "might have a revolution.... This is the 90's...patient power." She knew she had the support of the patient community, and as a result of this support she knew she could continue with her workshop. I also suggest that even her most fervent adversary acknowledged this aspect of capital as a stake in the struggle between groups, in the thought that Reinhart attributes to him:

...Maybe she's onto something here....Well, even if this isn't right this

might be the trend. If I'm going to be politically correct, then I'd better not squash it.

Knowing she had patient support as a form of symbolic capital, Reinhart then used its other aspect: as a weapon. As a result, the hospital administration agreed to allow her to continue to offer her coping skill courses.

Thus, having analysed my fieldwork from Bourdieu's theory of social change, I argue that it supports Bourdieu's thesis that culture is dynamic and that change takes place out of contestation and competition between groups.

In this chapter, I have analysed my fieldwork on visualizations as they are conceptualized in the Ottawa Hull region. During this analysis, I revealed several issues which have influenced the acceptance or rejection of visualizations as having a role to play in biomedical practices. I discovered that patients often abandoned their visualizations. I learned that patients who were unsuccessful with their visualizations tended to blame themselves, and that physicians such as Grenville considered the idea that visualizations could effect physical changes as invalid. At the same time, I showed that visualizations have been included in the treatment of cancer and arthritis. However, on the basis of my fieldwork, I would argue that visualizations have not been accorded an unqualified welcome into biomedical practices. Rather, I suggest that they have been given a restricted role. In most instances, their role, has been to help patients deal with psychosocial issues surrounding their cancer or arthritis, such as anxiety, pain and depression. Visualizations, I argue, have not been accepted as having a role in effecting physical changes.

Chapter 6

Conclusion

In the introduction to my thesis, I made a statement, based on my experiences as a physiotherapist and as a member of North American culture that "... within the past 20 years, it is my impression that the use of visualizations has quietly emerged in our western medical practices, particularly in the treatment of diseases such as cancer and arthritis." Based on this impression, I hypothesized that the use of visualizations techniques in the treatment of diseases such as cancer and arthritis is an expression of cultural change. I stated that if in fact, visualizations are part of biomedical practice, it would be indicative of a softening of the mind-body dualism and a shift away from its reductionist approach to treatment which have characterized biomedicine since the seventeenth century. Furthermore, again, based on personal observation of the clash between biomedicine and the alternative systems of medicine, I argued that this social change would have taken place within the context of contestation. For this reason, I chose Pierre Bourdieu's theory of cultural change which subscribes to the argument that social change does, in fact, take place within a context of struggle and competition.

Related to these issues, I set out to do three things. One: to substantiate my impression that visualizations have been incorporated into biomedical practices, and at the same time, to come to understand how they are conceptualized. Two: to show evidence that a shift or change in biomedical tenets, particularly with reference to its doctrine of mind-body dualism had occurred, thus, providing an explanation of the inclusion of visualizations in biomedical practice. Three: to show that a change in biomedical beliefs and practices would occur within a context of struggle and contestation.

To achieve my first goal, I explored the extent of the use of visualizations not only in the field of medicine but also in other domains within North American culture. I discovered that visualizations are used in the field of psychology and psychiatry, the birthing process, sports, and dance. In my literature search which included what Lerner calls the 'inspirational press', I found that visualization therapists such as Brigham, Achterberg, Naparstek advocate the use of imagery(including visualizations) for many different ailments. These therapists also advocated specific criteria

and guidelines in doing imagery work. They grounded their understanding that visualizations could effect physical changes in the theoretical framework of psychoneuroimmunology which I discussed in my thesis.

However, as a result of my research of the professional biomedical literature, I discovered a discontinuity. I found that in the majority of these studies visualizations were not conceptualized as having physical effects. I found almost no discussion of the physical effects of which Achterberg or Simonton spoke. Rather, visualizations were conceptualized as being helpful in dealing with the psychosocial dimensions of cancer and arthritis, thus reinforcing mind-body dualism. As a consequence of doing my fieldwork, for the most part, I drew a similar conclusion.

Based on my research into the biomedical literature and in doing my fieldwork, I conclude that visualizations have entered biomedical practices, conceptualized, predominately as having psychosocial effects rather than physical ones. Still, I suggest that even in this capacity, their use is indicative of a shift in biomedical practices. Their use represents a move away from a reductionist approach to treatment in which the focus is on the body and physical measures of treatment. Now, social and psychological parameters of disease are being considered, resulting in a more holistic approach to patient care.

Related to my second objective, that of identifying developments within and external to biomedicine which might account for the inclusion of visualizations into biomedical practices, I attempted to identify developments within biomedicine itself which would 'heal' its mind/body split, thereby providing a rationale for the inclusion of visualizations in biomedical practices. I found evidence for a framework of mind-body connections in phenomena such as biofeedback, the neurosciences, and especially in the relatively new field of psychoneuroimmunology (PNI). This field has provided biomedicine with a theoretical framework to understand the interconnections between mind and body, as well as a rationale to dissolve its notion of dualism. Also, it has provided the theoretical basis for those in the health field, such as Brigham, or psychooncologists who advocate the use of mental strategies in the treatment of disease. In addition, visualization therapists such as Achterberg, Brigham, Naparstek, and informant Sperling, based their understanding of the mind's effect on the body on these

psychoneuroimmunological principles.

Looking beyond the biomedical field into the alternative systems of medicine, my research findings revealed that many of the practices within these system have as their conceptual framework one that espouses the unity of mind and body. Looking even further, into the world of quantum physics, I discovered evidence of a mind-body monism in David Bohm's theory of soma significance.

As a result of my research into these developments within and external to biomedicine, I found data to support explicit links between mind and body. In other words, I discovered that the ingredients for a dissolution of biomedicine's mind-body dualism were present. Yet, I have shown in my thesis that this dissolution hasn't happened. For example, informant oncologist Grenville rejected the capacity of visualizations to shrink tumours. Reinhart's patients who were taught visualizations discontinued them because, I suggest, they lacked faith in the ability of visualizations to make physical changes in their cancer. Angell, in the New England Journal of medicine which represents the biomedical establishment, strongly rejected mind-body beliefs and practices of those in the PNI field, considering them to be unethical and dangerous.

To answer the question, why? Why has the belief in mind-body dualism remained intact, by and large, within the biomedical community and in the minds of patients such as those with whom Reinhart came in contact? I looked for, and found the answer in Pierre Bourdieu's theory of cultural change which relates to the third goal of my thesis: that a change in biomedical beliefs and practices would occur within a context of contestation and competition.

Bourdieu's theory of cultural change, as I have described in my thesis, proposes that cultures are dynamic and that social change occurs within a context of contestation. Using his concepts of *field*, *habitus* and *capital*, Bourdieu offers an explanation of how and why change occurs, and how and why it may be resisted. In my thesis I applied these concepts both to biomedicine's relationship with the alternative systems of medicine and to my fieldwork on visualizations.

Using his concepts of field and habitus, I showed why biomedicine, by and large, has resisted changes to its tenets such as mind-body dualism, and its

reductionistic approach to treatment. Using Bourdieu's concept of capital, I illustrated how the biomedical establishment was able to maintain control over its views and practices. As an example, I revealed how the biomedical establishment used its symbolic capital of scientific methodology to discount the research findings of Simonton whose seven year outcome study (1974-81) showed that cancer patients who did this type of 'mind' work lived twice as long as those who did not. I showed how biologically based research bodies used their economic capital as a weapon, to direct research funds away from studies which might challenge their notion that mental strategies have no physical effects. As I mentioned in my thesis, in 1984 Cunningham of the Ontario Cancer Institute had issued a plea to the biomedical community to subject the claims of these studies to "properly controlled" clinical trials (Lerner, 1994:153). As well, despite his efforts, Simonton was unable to obtain funding to repeat his studies, using a randomized control format which would give it the necessary credibility in the eyes of the biomedical community.

At the same time, I illustrated Bourdieu's notion that change occurs within context of struggle, showing that groups such as visualization therapists, health practitioners within the field of psychoneuroimmunology, as well as those within the alternative system of medicine, are contesting biomedicine's power to set the prevailing framework for medical beliefs and practices; these groups are using symbolic capital of their own: that of public patronage and esteem. As a result of these challenges, I suggested, that changes in medical practices have occurred, illustrating Bourdieu's notion of the dynamic quality of culture. For example, physiotherapists Kinch and McCaffery now include visualizations in their practices. Sperling conducts transformational fantasy sessions with her patients, and at the Civic hospital cancer centre, psychosocial dimensions of treatment are available in conjunction with the physically based measures of surgery and chemotherapy. Indeed, the establishment of an office for the study of Alternative medicine within the National Institute of Health which epitomizes the American biomedical establishment, is a strong indication of a change in the practice of biomedicine. Closer to home, according to Barber, the University of Ottawa medical school since 1992 has based its curriculum on a biopsychosocial model rather than on a biomedical one, reflecting a more

holistic approach to the care and treatment of patients(personal communication, May 16,1996).

In conclusion, I argue that in showing that visualizations have been incorporated into biomedical practices and that their inclusion is indeed, an expression of social change, my thesis is a valid one. However, the incorporation of visualizations into biomedical practices is not indicative of a softening of the biomedical tenet of mind-body dualism, as I had hypothesized. Rather, I argue that their inclusion represents a shift away from biomedicine's epistemology of reductionism in its treatment of disease towards a more holistic approach to patient care.

Furthermore, based on my research findings, I have shown that culture is dynamic. I have provided evidence that change takes place in a milieu of contestation between groups who wish to transform the social universe in some way and those who wish to preserve the status quo. As a result, I argue that Bourdieu's theory of cultural change offers an excellent explanation of what has happened in biomedicine in terms of its relationship with visualization practices. I suggest therefore, that I have been able to achieve one of the goals of my thesis: to illustrate the adequacy and relevancy of one of the theoretical frameworks from which anthropology attempts to understand humankind, thereby making a contribution to the discipline of anthropology itself.

Bibliography

- Achterberg, J.,
1985 *Imagery In Healing: Shamanism and Modern Medicine.*
Boston and London: Shambala
- Acupuncture Foundation of Canada Institute Publication.
June 24, 1995
- Bandler, R. and Grinder, J.,
1985 *Frogs into Princes: Neuro Linguistic Programming.*
Moab: Real People Press
- Barber, A.,
1996 Personal Communication. May 16, 1996
- Bernard, H.R.,
1988 *Research Methods in Cultural Anthropology.*
Newbury Park: Sage Publications, Inc.
- Billington, C.
1995 Panel discussion. May 26, 1995.
World Congress of Mental Training. Ottawa.
- Bohm, D.
1989 "Meaning and Information." Pp. 43-86 in Paava Pylkkanen
(ed.), *The Search for Meaning: The New Spirit in Science
and Philosophy.* Wellingborough: Crucible
- Bourdieu, P.
1977 *Outline of a Theory of Practice.* Cambridge: Cambridge
University Press
- Bourdieu P. and Wacquant L,
1992 *An Invitation to Reflexive Sociology.* Chicago:
University of Chicago Press
- Bradley, F.H.,
1964 "René Descartes." Pp 22-48 in G.N.A. Vesey (ed.),
Body and Mind: Readings in Philosophy.
London: George Allen and Unwin Ltd.
- Brants, W. & Gugeler, J.,
1995 *Debate: Alternative Medicine. Remedy or Quackery.* The
Ottawa Citizen. Tuesday, November 7
- Brain/Mind Bulletin
September, 1994 Volume 19, Number 12 *Journal Breaks New
Ground in Tracking Alternative Care.* page 7

- Brigham, D.,
1994 *Imagery for Getting Well: Clinical Applications of Behavioural Medicine.* New York: W.W. Norton Co.,Inc.
- Burgess, R.,
1984 *In the Field: An Introduction to Field Research.* London: George Allen and Unwin
- Campbell,K.,
1970 *Body and Mind.* London and Basingstoke: Macmillan Press
- Capra, F.,
1982 *The Turning Point: Science, Society, and the Rising Culture.* Toronto: Bantam Books
- Chisholm,P,
1995 *Healers or Quacks.* McLeans Magazine September 25 1995
- Copleston, F.,
1960 *A History of Philosophy.* Volume IV Descartes to Leibniz London: Burns and Oates
- Crapps, R.W.,
1986 *An Introduction to Psychology of Religion.* Macon: Mercer University Press
- Cunningham, A.
1992 *The Healing Journey:Overcoming the Crisis of Cancer.* Toronto: KeyPorter Books Ltd.
- Dilts, R., Grinder, J., Bandler, R., Bandler, L., DeLozier, J.,
1980 *Neuro-linguistic Programming: The Study of the Structure of Subjective Experience.* Cupertino: Meta Publications
- Dossey, L,
1992 *Meaning and Medicine.* New York: Bantam Books
- Durtschi, M.K.
1995 *Personal Communication.* May 25, 1995 World Congress of Mental Training in Excellence. Ottawa Canada

- Eisenberg D. et al
1993 *Unconventional Medicine in the United States.* New England Journal of Medicine. Volume 328, No.4 Jan.28, 1993
- Engels
1977 *"The Need for a New Medical Model: A Challenge for Biomedicine."* Science, April 8. Vol.196 Number 4286
- Epstein, G.
1989 *Healing Visualizations: Creating Health Through Imagery.* New York: Bantam Books
- Felten, D.
1991 *A Personal Perspective on Psychoneuroimmunology."* Pp1117-1120 in R. Ader, D. Felten and N. Cohen (ed.), *Psychoneuroimmunology.* Toronto: Academic Press
- Geertz C.,
1973 *The Interpretation of Cultures.* New York: Basic Books
- Gendlin, E.,
1978 *Focusing.* New York: Bantam Books
- Grof, S.,
1988 *The Adventure of Self-Discovery.* Albany: State University of New York Press
- Gorman, J. and Locke,S.
1989 *"Neural, Endocrine, and Immune Interactions."* Pp111-125 in Harold I. Kaplan, M.D. and Benjamin J. Sadock (eds.), *Comprehensive Textbook of Psychiatry.* Baltimore: Williams and Wilkins
- Gould, D.
1996 Personal Communication. May 25, 1996
- Gyatso, K.
1988 *Universal Compassion.* London: Tharpa Publications
- Hall, Howard
1990 *"Imagery, Psychoneuroimmunology and the Psychology of Healing."* Pp. 203-227 in Robert G.Kunzendorf and Anees A.

Sheikh (eds.), *The Psychophysiology of Mental Imagery*.
Amityville: Baywood Publishing Co., Inc.

Hammersley, M. and Atkinson, P.,
1991 *Ethnography: Principles in Practice*. London: Routledge

Hanrahan,
May 25, 1995 Personal Communication.
World Congress of Mental Training in Excellence.
Ottawa. Canada

Holt, R.R.,
1964 *Imagery: Return of the Ostracized*. American Psychologist
19:254-264

Humphreys, C.
1951 *Buddhism*. Harmondsworth: Penguin Books

Jones, C.,
1987 *Mind Over Labour*. New York: Viking Penguin Books

Jung, C.,
1968 *Man and His Symbols*. New York: Dell Publishing Co. Inc.

Kunzendorf, R.
1990 "The Causal efficacy of Consciousness in General, Imagery
in Particular: A Materialist Perspective." Pp.147-153 in
Robert G. Kunzendorf (ed.), *Mental Imagery*. New York:
Plenum Press

Landaw, J. and Weber, A.,
1993 *Images of Enlightenment: Tibetan Art in Practice*.
Ithaca: Snow Lion Publications

Lerner, M.,
1994 *Choices in Healing: Integrating the Best of Conventional
and Complementary approaches to Cancer*. Cambridge: The
MIT Press

Locke, S. and Colligan, D.,
1986 *The Healer Within: The New Medicine of Mind and Body*.
New York: E.P. Dutton

McMahon, C. and Sheikh, A.
1986 "Imagination in Disease and Healing Processes: A Historical
Perspective." Pp.1-36 in Anees A. Sheikh (ed.), *Anthology
of Imagery Techniques*. American Imagery Institute.

- McGuire, R.
1995 *Herbal Medicine for Menopause gets U.S. trial.* Medical Post, October 17, 1995
- Melton, J., Clark, J., and Kelly, A.,
1991 *New Age Almanac.* New York: Visible Ink Press
- Morris, B.,
1985 "Hypnotherapy of Warts Using the Simonton Visualization Technique: A Case Report." *American Journal of Clinical Hypnosis.* Volume 27, Number 4, April 1985
- Naparstek, B.
1994 *Staying Well with Guided Imagery.* New York: Warner Books, Inc.
- Noll, R.
1985 "Mental Imagery: Cultivation as a Cultural Phenomenon: The Role of Visions in Shamanism." *Current Anthropology* Vol. 26, No. 4 August-October 1985
- Pelton, R. and Overholser, L.,
1994 *Alternatives in Cancer Therapy: The Complete Guide to Non-Traditional Treatments.* New York: Simon and Schuster
- Pribram, K.,
1986 *The Cognitive Revolution and Mind/Body Issues.* Journal of the American Psychological Association Volume 41 May 1986 Number 5
- Pylkkanen, P.
1989 Introduction Pp. 1-39 in Paava Pylkkanen (ed.), *The Search for Meaning: The New Spirit in Science and Philosophy.* Wellingborough: Crucible
- Riley, D.,
1995 "Research, Homeopathy, Therapeutic Consultation". in *Alternative Therapies in Health and Medicine.* September 1995 Vol 1, No.4
- Rosenbaum, L.
1989 *Biofeedback Frontier: Self Regulation of Stress Reactivity.* New York: AMS Press
- Rubick, B.,
1995 *Can Western Science Provide a Foundation For*

*Acupuncture? in Alternative Therapies in Health and
Medicine. September 1995 Vol. 1, No.4*

- Samuels, M. and Samuels, N.
1975 *Seeing With the Mind's Eye*. New York: Random House and
La Jolla: The Bookworks.
- Sawyer, D.,
1986 "How Jungians Work with Images." Pp.391-412 in Anees A.
Sheikh (ed.), *Anthology of Imagery Techniques*. American
Imagery Institute.
- Schneider, J., Smith, W., Minning, C.,Whitcher, S., Hermanson, J.,
1990 "Guided Imagery and Immune System Function in Normal
Subjects: A Summary of Research Findings." Pp.179-191 in
(ed.) Robert Kunzendorf, *Mental Imagery*. New York:
Plenum Press
- Schonauer, Klaus
1994 *Semiotic Foundations of Drug Therapy: The Placebo Problem
in a New Perspective*. Berlin: Mouton de Gruyter
- Simonton, C., Matthew-Simonton, S., and Creighton, J.,
1978 *Getting Well Again*. Los Angeles: J. P. Tarcher
Inc.
- Simonton, C., and Henson, R.,
1992 *The Healing Journey: Restoring Health and
Harmony to Body, Mind and Spirit*. Bantam
Books: Toronto
- Smith, D.,
1990 "Imagery in Sport: An Historical And Current
Overview." Pp.215-224 in (ed.), Robert G.
Kunzendorf's *Mental Imagery*. New York and
London: Plenum Press
- Spiegel, D.
1991 "A Psychosocial Intervention and Survival Time of
Patients with Metastatic Breast Cancer." *Advances:
The Journal of Mind-Body Health* Vol.7, No.3
Summer 1991
- Turner, J. et al
1994 *The Importance of Placebo Effects in Pain
Treatment and Research*. JAMA. 1994;271:1609-1614

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